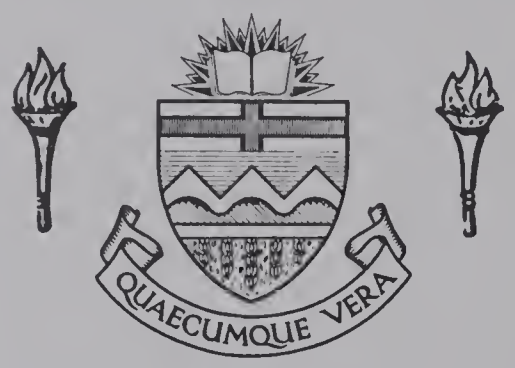

THE UNIVERSITY OF ALBERTA

AN EXAMINATION OF THE ECONOMIC AND ADMINISTRATIVE STRUCTURE OF HEALTH CARE PLANS IN CANADA

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF MASTER OF HEALTH SERVICES ADMINISTRATION

DIVISION OF HEALTH SERVICES ADMINISTRATION

DEPARTMENT OF COMMUNITY MEDICINE

EDMONTON, ALBERTA

FALL, 1970

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled AN EXAMINATION OF THE ECONOMIC AND ADMINISTRATIVE STRUCTURE OF HEALTH CARE PLANS IN CANADA submitted by Lawrence J. Nestman in partial fulfilment of the requirements for the degree of Master of Health Services Administration

ABSTRACT

The passage of the Federal Medical Care Act by the Parliament of Canada established certain criteria that are required for the organizing and financing of health insurance by the Provincial Governments. The provinces have responded to this legislation in a number of different ways. The main objective of this thesis is to compare and contrast differences, and to consider the significance of such differences.

The basic conclusion of this thesis is that the lack of comparability and consistency in the administrative and economic structure of health care plans in Canada is primarily due to two major reasons:

(1) The lack of socio-economic analysis (or the implementation of such analyses) required to formulate the most effective and efficient ways of administrating health care plans.

(2) The lack of federal government action in establishing standards which minimize the administrative costs and maximize the net health care benefits obtained from the plans.

ACKNOWLEDGEMENTS

I would like to express appreciation and thanks to Professor R.H.M. Plain for his ready and helpful assistance, his enlightening discussions and his wise counsel concerning the thesis as a whole.

My sincere gratitude is extended to my wife, Ann, whose patience and resourcefulness allowed me to concentrate on writing this thesis, and whose cheerfulness and support were a constant inspiration to me.

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CHAPTER I

INTRODUCTION

Purpose

> "To be free from want, to be more certain of finding sustenance, health, steady employment; to enjoy a larger measure of responsibility without oppression, sheltered from situations which offend the dignity of man; to be better educated, in a word to achieve, know and have more in order to be more: such are the aspirations of man today."[1]

Canada, in common with many other countries has witnessed a rapid evolution in the health and welfare fields. The technology of modern medicine has moved forward rapidly in the present century and this has led to a re-appraisal of organizations designed to provide health and social services. These advances have been paralleled with increased costs and different methods of financing health services. Canada has substantially changed the administrative structure of the health care delivery systems and the method under which payments are made for health care services. The most recent change was initiated by the Federal Medical Care Act.[2] The provinces have responded to this legislation in a number of different ways. The main object of this thesis is to compare and contrast differences and to consider the significance of such differences. A comparison of Hospital Insurance Plans with Health Insurance Plans is attempted

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[1]Encyclical Popularum Progressis of H.H. Pope Paul VI.

[2]Canada. Medical Care Act. 14-15 Elizabeth II, Chapter 64 (Ottawa: Queen's Printer, December 21, 1966).

where a comparison can readily be made.

Scope

It would be an enormous task to identify all federal and provincial legislation which relates to health insurance. As a result, a large body of legislation that directly and indirectly affects the administrative and economic structure of health insurance will not be considered i.e., legislation organizing the various provincial professional medical organizations, workmen's compensation, etc. This study is restricted to two specific types of provincial legislation specifically enacted by the provinces to establish health insurance plans.

(1) Individual Provincial Health Insurance Acts

(2) Individual Provincial Health Insurance Regulations

The nature and terminology of such legislation vary considerably from province to province. With regard to the legislation no attempt was made to present a detailed comparison of benefits, methods of financing, etc. The study was carried out by the author with the appreciation that while a great deal of information could be obtained with regard to the various areas under review, it would not be possible to develop the various areas in depth. This would require not only trained investigators, but also specialists with a great deal of background knowledge.

Format of Thesis

The thesis is divided into five chapters. Chapter I consists of the introduction, scope of study and terminology. The section on terminology indicates some of the important terms and

expressions used throughout the thesis. In Chapter II an attempt is made to provide an overview of Health Care Systems in general. The Canadian Health Care System is examined as a sub-set of this general system. Some of the constitutional dilemmas concerning health insurance are presented. The chapter concludes with a general outline of the Federal Medical Care Act. Chapters III and IV describe specific organization and economic principles and techniques of the individual provincial health insurance plans. Chapter V, the final chapter, gives a summation of the similarities and dissimilarities of the individual provincial health insurance plans.

Definitions

Health Services - refers to those services which are designed to promote, preserve and restore health and to minimize the effects of illness on the individual and the community.

Health Insurance - refers to systems or programs organized under the auspices of the provincial and federal governments to provide payments for health services rendered to the Canadian populace. There are two basic types of health insurance plans. Under an "indemnity" plan a consumer is guaranteed compensation for his expenses up to a certain fixed maximum level for each type of service. Charges beyond the maxima established under the plan must be borne by the consumer. Under a "service" plan the consumer has the actual services provided to him by the plan or the plan pays the cost of the health services. Under some "service" plans a small additional charge may be made at the time the service is rendered.

Health Benefit - refers to a named health service provided by a health insurance program.

Schedule of Benefits - refers to a listing of the amounts which will be paid for various health benefits under a Provincial Health Insurance Plan.

Schedule of Fees - refers to the set of prices recommended by various professional associations for services rendered by accredited members of the organization.

Additional Charges at the Time of Service - Payment of health benefits by a Provincial Health Insurance Plan does not necessarily cover the total cost of services received in the sense that an individual may be required to make an additional payment. These payments at the time of service are frequently referred to as utilization charges, insurance authorized charges, deterrent charges, etc. Rather than adopt any of these terms, the charges will be referred to as "additional charges at the time of service."

Insured Person - refers to a person entitled to insured services under a plan in the province in which he is a resident.

Participating Province - refers to a province which operates a health insurance plan. The plan is eligible for a contribution by the Federal Government under the Medical Care Act of Canada.

Participating Practitioner - refers to a practitioner who receives reimbursement from a provincial health insurance plan for service(s) rendered.

Intermediary Agencies - refers to organizations that collect premiums (if applicable) and make payments for insured services. These agencies cannot assess claims or determine the amount paid for these health services; however, these agencies may sell premiums, assess claims and determine the amount of payment for health services that are not insured services.

Commission - refers to two or more persons appointed by the Lieutenant Governor in Council or by various professional, business, or labour groups. It is the commission's duty to assess claims and determine payments for provincial health insurance plans.

Mandatory Groups - refers to an organization in Ontario consisting of fifteen or more employees. It may also be an organization in Ontario consisting of at least five but less than fifteen employees who elect themselves to be designated as a mandatory group. In a mandatory group all persons are required to be members of the Ontario Health Service Insurance Plan.

Collector's Group - refers to a group in Ontario consisting of five or more persons and one person is elected to collect the premiums for the group. The group has the approval of Ontario Health Services Insurance Plan.

CHAPTER II

BACKGROUND TO HEALTH INSURANCE

Health Care Systems

K.C. Charron[1] has pointed out that there are four basic systems associated with the organization, financing and provision of health services. These are as follows:

1) Private Enterprise - Under this system private practice is emphasized, hospitals are usually voluntary, and the patient frequently pays for health care services directly. Health insurance[2] is left to non-profit or commercial insurance organizations.

2) Social Assistance - Under this system the parts of the population receiving financial aid through various welfare programs are entitled to medical care. The welfare agency pays doctors in private practice for these services. This type of arrangement may be extended to other low-income groups.

3) Social Insurance - Under this system the state provides fiscal assistance for health services. The availability of health

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[1] K.C. Charron. Health Services, Health Insurance and Their Inter-relationship: A Study of Selected Countries (Ottawa: Department of National Health and Welfare, November 7, 1963), p. 9.

[2] The word "medicare" has acquired many political, economic and cultural meanings over the last few years. For this reason, the author has decided not to use the term "medicare." The term "health insurance" will be used instead.

resources, effective utilization of services and the standards of health care are not the responsibility of the social insurance agency.

4) Public Service - Under this system, the direct responsibilities of the plan are the financing of health services and the concern with its quality, availability and effective utilization[3] e.g., United Kingdom.

Charron says there is an inevitable trend in health care systems to move from 1) through 4). Odin W. Anderson states,

> "The shift in many countries from privately sponsored health insurance to government-sponsored health insurance has been regarded as an inevitable historical process by both those who favor and those who oppose government-sponsored health insurance. Some regard privately sponsored health insurance as inherently inadequate, and others as the beginning of the trend toward governmental intervention."[4]

It is hard to state with certainty why this trend takes place. If there were agreed-on measures of efficiency and effectiveness of various health service systems, there would be little difficulty in deciding which one would provide the best service at the least cost to the most people. Katz and Kahn have noted,

> "There is no lack of material on criteria of organizational success. The literature is studded with references to efficiency, productivity, absence, turnover, and profitability--all of these offered implicitly or explicitly, separately or in combination,

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[3] A fifth system can also be said to exist, e.g., Soviet Union. It is not only concerned with the financing, quality, availability and effective utilization of health services but also with the direct hiring of all personnel and the erection of all facilities.

[4] Odin W. Anderson. Medical Care: Social and Organizational Aspects. A Symposium of Selected Papers, Compiled and Edited by Leslie I. DeGroot (Springfield, Illinois: C.C. James, 1966), p. 220.

> as definitions of organizational effectiveness. Most of what has been written on the meaning of these criteria and on their interrelatedness, however, is judgmental and open to question. What is worse, it is filled with advice that seems sagacious but is tautological and contradictory."[5]

Before the health care system can be efficient and effective, it must come to grips with the central problem--what is quality care? "Everyone agrees that high quality is desirable but no one has been able to develop a comprehensive definition that will meet all the tests of completeness."[6] Until we have defined adequately what "quality" is and until we operationalize criteria that will evaluate quality adequately, the problem of achieving an optimum allocation of resources in the health care system will be difficult to resolve.

Since concrete criteria are lacking, debaters on public policy have become very opinionated. Differences of opinion have become based on value judgements regarding the proper role of government.

One point, however, seems evident. There is confusion concerning the primary purpose of health insurance.[7] Is its purpose to

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[5]Daniel Katz and Robert L. Kahn. The Social Psychology of Organizations (New York: John Wiley & Sons Inc., 1966), p. 149.

[6]Richard Weinerman. "Research into the Organization of Medical Practice," Milbank Memorial Fund Quarterly (New York: Milbank Memorial Fund, October, 1966), p. 120.

[7]In some countries e.g., U.K., the term "health insurance" includes hospital care, suitable accommodation, physician care and all required drugs. However, in North America, Hospital Insurance is concerned only with the essential items of hospitalization. In Canada generally this would be services provided under the Hospital Insurance and Diagnostic Services arrangement. Also in North America Health Insurance by surgeons and physicians and/or their auxiliaries, is organized and financed quite independently of hospital insurance. In Canada generally this would be services provided under the Federal Medical Care Act (to be discussed later). It should be noted that the last province to enter the Hospital and Diagnostic Services arrangement was in 1961. This was five years earlier than the passage of the Federal Medical Care Act in 1966. Thus, in the Canadian health care system, the distinction between health insurance and hospital insurance is quite clearcut.

provide comprehensive health services for the population, or is it to spread the magnitude of costs from individuals to groups? This confusion seems to indicate that the system is presently undergoing a transition from a system which "buys" services (Social Insurance) to one that "provides" services (Public Service).

The Canadian Health System seems to fit in this perspective in the following manner. Charron[8] notes that the hospital portion of the health delivery system has gone through the steps one to three. He argues that the Hospital Insurance and Diagnostic Services arrangement in Canada has reached the point where it is midway between social insurance and public service. The provision of medical services has advanced to stage three. This conclusion is based on the following sets of observations. The Federal Medical Care Act defines itself to be an "Act to authorize the payment of contributions by Canada towards the cost of insured medical care services incurred by provinces pursuant to provincial medical care insurance plans."[9] The "Act" does not provide for the hiring of health personnel or for the provision of facilities for patient care. It does not set out standards of quality care. In effect, the availability and accessibility of health services are not guaranteed. The "Act" is primarily a mechanism to "buy" health services and thus it ensures only that there is not a financial barrier between the providers and consumers

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[8] K.C. Charron. Op. cit., p. 10.

[9] Canada. Medical Care Act. Op. cit., Introduction. The "Act" defines insured services as all services that are medically required except those services that a person is eligible for under other federal and provincial statutes. Sec. 2(e), p. 563.

of health services.[10]

Canadian Health Care System

Constitutional Aspects of Health Care Legislation in Canada

The search for ways and means of insuring the availability of adequate personal health services to every individual in our country has been one of long duration and elusiveness. One of the major problems, which indeed is common to implementation of most large scale social legislation in Canada, is the lack of certainty as to which level of government has the right and responsibility to implement health legislation. A major portion of the uncertainty stems from the lack of specific mention in the British North America Act as to which level of government (federal or provincial) is responsible for health insurance legislation.[11]

It was assumed in 1867, or so it seems, that health and welfare were the responsibility of the provinces and this assumption has hardened in time, through custom and legal interpretation into

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[10]While there are exceptions to the rule, one can note here an overall difference in approach between Canada, the United Kingdom and United States. Canada is progressively providing major segments of personal health care on a publicly financed basis to virtually her whole population. In the United States, on the other hand, the pattern appears to be that of singling out portions of the population by age, as in Medicare. In this context, United States has selected a "Social Assistance Approach." The United Kingdom on the other hand has selected not only a finance mechanism to cover health costs but also has undertaken to provide these services. This is a"Public Service" approach.

[11]Barbara N. Rodgers, John Greene, and John S. Morgan. Comparative Social Administration (New York: Atherton Press, Inc., 1968), p. 164.

established doctrine.[12] Schmeister has noted that "judicial misconstruction of sections 91 and 92 has nullified, with only a few exceptions, the residuary power of the Dominion and has transferred this power to the provincial domain, under the guise of property and civil rights."[13] There are also those who argue that the welfare of the Canadian people is the concern of all governments.[14] However, in legal interpretation and in practice, health is generally recognized as a provincial responsibility. The issue becomes even more complex because the interpretation of the division of the taxation fields is such that the federal government has the major revenue producing areas.[15] In practice the dilemma has been that the essential taxing power is at one level, while the jurisdictional power in the field of health and welfare is at another. As a result, some provinces (e.g., Atlantic Provinces) have not had the fiscal capacity to raise sufficient funds to meet their responsibilities in the fields of health.

Federal Health and Welfare Legislation

The Federal Government has responded in two ways:

1) The first has been for the Federal Government to obtain

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[12] D.A. Schmeister. Civil Liberties in Canada (Toronto: Oxford University Press, 1964), p. 9.

[13] Ibid., p. 9.

[14] F.R. Scott. "Proceedings of the Royal Society of Canada" (Third Series, Vol. 55, 1961, Presidential Address), pp. 83-85.

[15] S.N. Gellier. "Public Medical Care Plans in the Provinces--The Current Situation." A Symposium of Papers: Health Services in Canada (Ottawa: Mutual Press Ltd., 1965), p. 29.

an amendment to the British North America Act 1867 to permit the Federal Government to undertake certain social services. Two amendments affecting health and welfare have so far been made to the British North America Act 1867. In 1940 an amendment was made to Subsection 2 of Section 91 to add a new Subsection 2A for Unemployment Insurance. The other amendment was made to create federal jurisdiction for old age pensions[16] (passed by United Kingdom, July 31, 1964). In August 1964, the Federal Government issued a White Paper[17] on the Canadian Pension Plan in which it set out its proposals for a universal contributory social insurance scheme to cover retirement, death benefits and benefits for dependent survivors, including widows and orphans of insured persons. This proposal, after negotiations to reconcile the proposals with those of the Province of Quebec, was passed in April, 1965. Rodgers notes, "The constitutional significance of this plan is that it plainly recognizes that social insurance is an area of shared jurisdiction in which the provinces have prior rights."[18] The Canada Pension Plan includes a provision that a province may establish its own plan and be exempted from the provisions of the federal plan if its benefits are comparable to those provided in the Canadian Pension Plan Act. The only province

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[16]This amendment replaced an earlier amendment. Barbara N. Rodgers notes that "the original amendment was replaced because it presents a new problem in the matter of the divsion of power, because it apparently divides the subject by entrusting it partly to federal jurisdiction and partly to provincial jurisdiction." Barbara N. Rodgers, John Greene, and John S. Morgan. Op. cit., p. 166.

[17]Canada Department of National Health and Welfare. The Canada Pension Plan (Ottawa: The Queen's Printer, August 1964).

[18]Barbara N. Rodgers, John Greene and John S. Morgan. Op. cit., p. 167.

that has established its own plan is the Province of Quebec.

2) The second method used to secure federal participation in health and welfare has been the use of what has been described as a "legislative expedient." Rodgers notes that this device was first used in 1926 by the federal government to implement old age pension legislation.[19] Generally, the federal government, using its power to expend the general revenue as it sees fit, makes grants available to any province on condition that the province pass legislation which includes and is not contrary to the conditions specified in the federal legislation. Then the Provincial government makes an agreement with the federal government under which the province will obtain the federal monies under specified detailed conditions. The Canada Assistance Plan, enacted in July 1966, is the most sophisticated and the most flexible of these federal initiatives to assist in the development of better social services without infringing on provincial constitutional rights.

The latter device has recently been directly challenged in a report of considerable importance by the Province of Quebec.

> "The Quebec Government should pursue and intensify its efforts in order to obtain the withdrawal of the Federal Government from joint social assistance programs and have the Federal Government compensate through extension of taxation fields, the Province of Quebec's increased expenditure arising therefrom."[20]

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[19] Ibid., p. 169.

[20] Quebec. Rapport du Comete d'etude sur l'assistance publique. Quebec, 1963 Report of the Study Committee on Public Assistance (Quebec: Queen's Printer, 1963).

The grounds on which this recommendation is justified are significant.

> "Section 92 of the British North America Act confers on the provinces the right to pass their own social security legislation. All the provinces, including Quebec have long played a passive role in this field, and have been satisfied to follow the Federal Government by agreeing to joint programs. Too often, their sole concern was centered on recuperating sums reverting to them. In a word, the social legislation of Quebec should be the product of its own thinking, instead of a meeting point of several different statutes more or less inter-related by a context quite different from that of Quebec."[21]

Rodgers has noted that,

> "If the position taken in the 1963 Report of the Quebec Study Committee on Public Assistance Legislation accurately reflects the official position of the government of that province, and there is good reason to believe that it does, and if this position is supported over the next decade by other powerful provincial governments, the whole fabric of social legislation may have to be rewoven in the light of a new balance of constitutional powers. This will be reflected in part by constitutional amendment and in part by reinterpretation of the constitution in new and as yet unfamiliar ways."[22]

However, the Federal Government has never been called before the courts to justify the conditional grants it has made since 1913 for provincial purposes, such as public health, highways, technical education and agriculture. A.H. Birch asserted, "In Canada the power of the Dominion Parliament to impose conditions in connection with grants paid to the provinces has never been challenged in the courts."[23] L.M. Cougan and B.C. Claxton have also studied and examined "legislative expedients" used by the Dominion and the provinces and, more

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[21] Ibid., p. 114.

[22] Barbara N. Rodgers, John Greene and John S. Morgan. Op. cit., p. 168.

[23] A.H. Birch. Federalism, Finance and Social Legislation in Canada, Australia and the United States (London: Oxford Press, 1955), p. 162.

particularly, the question of federal grants, and they came to the following conclusion:

> "From the foregoing, it will seem that we are of the view that the Dominion may grant sums of money for any provincial purpose and the law granting the subsidy is only ultra vires when it deals actively with a provincial matter, that is to say, when it affects property and civil rights in the provinces."[24]

This phase of readjustment of political power between federal and provincial governments is not over and it may lead to substantial changes in the patterns of social services. For example, at the September, 1966 federal-provincial conference on fiscal resources, the Federal Minister of Finance stated that certain 'shared' programs in health and welfare should be returned entirely to provincial jurisdiction in return for the release to the provinces of increased revenue from taxation.

Types of Health and Welfare Legislation in Canada

In the context of the uneasy equilibrium of constitutional powers, social legislation in Canada can be grouped into three major categories.[25]

1) Federal legislation in respect of a limited number of federally operated programs, uniform for the whole country.

2) Federal-Provincial legislation in respect of programs

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[24]Canada. Report of the Royal Commission on Dominion-Provincial Relations, Legislative Expedients and Services. Adopted by the Dominion and the Provinces, Appendix 8 (Ottawa: Queen's Printer, 1939).

[25]Barbara N. Rodgers, John Greene and John S. Morgan. Op. cit., p. 169.

operated by the respective provinces under provincial legislation framed within the terms of an agreement between the federal and each of the provincial governments.

3) Provincial in respect of programs operated by, and financed and controlled by the respective provinces, or administered in some instances by municipalities within the province under provincial legislation.

The Federal Medical Care Act

The Medical Care Act was passed by the Parliament of Canada on December 21, 1966 and became operative on July 1, 1968.[26] The "Act" is a Federal-Provincial form of legislation and employs a "legislative expedient" to make it operative.

Administrative Aspects of the Medical Care Act

In order for a province to benefit from federal contributions:

1) The plan must be operated on a non-profit basis by a public authority set up by the provincial government. In respect of its accounts and financial transactions, the plan is subject to provincial audit. There is provision in the Act for provincial authorities to designate non-governmental organizations or agencies which would be permitted to undertake restricted functions in connection with the day-to-day premium-collection or claims-payment administration of the provincial plan. Thus, voluntary insurance

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[26]The vote tally in the House of Commons for the final passage was 177 in favor, 2 opposed. Although several Progressive Conservatives absented themselves when the vote took place, the opposition Leader John Diefenbaker rose in support of the measure. The two nay votes were Social Credit Members of Parliament.

carriers existing prior to the introduction of Health Insurance in a province might operate on an agency arrangement under the provincial authority. However, it would be necessary to handle this agency aspect of their business on a non-profit basis and the payment of medical claims would, in accordance with the Federal Act, be subject to assessment and approval by the provincial authority.

2) The Plan must make available on uniform terms and conditions to all insurable residents of the province, insured services, which are defined as "all medically necessary services rendered by general practitioners and specialists."[27] During the Commons debate on the Federal Medical Care Act, consideration was given to excluding certain medical services by physicians if these services could also be provided by non-physicians. The reasoning was that it would be inequitable to such practitioners as optometrists, if for example, a refraction or eye measurement service was an insured service only when provided by a physician. "Subsequent debate in the House revealed, however, a consensus that the orientation of the Act should be towards expansion, and not restriction, of insured services."[28] The Act in its final form allows the federal government to include additional health care services provided by non-physician professional personnel under terms and conditions specified by the Governor-in-

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[27] Except services that a person is eligible for and entitled to under any other act of the Parliament of Canada or under any law of a province relating to workmen's compensation.

[28] Resume of Medical Care Legislation. 1st Session, 27th Parliament (Ottawa: Health Research Division, Department of National Health and Welfare, March 18, 1967).

Council. Originally the Bill provided only for coverage of the services of physicians generally. As a result of subsequent debate, it was concluded that the federal legislation in its final form should be flexible enough to allow the inclusion of services rendered by non-physicians.

3) The plan must be universal. The Act defines universality to mean that the plan must give entitlement to not less than 90 percent of the number of eligible residents of the province during the first two years and not less than 95 percent thereafter. Lester Pearson noted "Since the basic reason for a federal contribution is to make medicare possible for all Canadians, it would hardly be logical to bring a federal contribution into play for plans not aimed at universal coverage."[29] All insured services must be provided to all Canadians without exclusion because of age, ability to pay, or other circumstances.

4) The plan must provide portability. The Act states that there must not be any minimum period of residence before a person is eligible for coverage of insured services. A three month waiting period for entitlement within a province is permissible.

Financial Aspects of the Medical Care Act

In general terms, the Act states that the federal contribution

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[29] Lester B. Pearson. Op. cit., p. 3.

to a participating province is an amount equal to 50 percent of the per capita cost for the year of all insured services in all participating provinces, multiplied by the number of insured persons in each such province, respectively.[30] Provincial expenditures for administering provincial plans are not items of cost which can be shared with the federal government and thus are excluded in calculation of per capita cost.[31] This method of calculating federal contributions to provincial plans is such that provinces with relatively low per capita costs are assisted by something more than half their provincial costs. By the same token, high cost provinces with, it is assumed, relatively greater ability to finance services from their own financial resources, are assisted by something less than half their costs.[32]

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[30]It is interesting to compare the above with recommendations of the Royal Commission on Health Services. The Commission recommended that the Federal Government contribute to the financing of such a program through federal grants in the following way:

1) A contributory grant of 50 percent of the actual cost;

2) An administrative grant of 50 percent of the administration costs of the program not to exceed five percent of the actual costs;

3) A fiscal need grant to assist provinces whose fiscal capacities are below the Canadian average to enable these provinces to provide health care services at standards comparable to the rest of Canada taking the factor of geography into account.

Canada. Royal Commission on Health Services, Vol. I (Ottawa: Queen's Printer, 1964), p. 84.

[31]Canada Medical Care Act. Op. cit., Sec. 5(4)(b) p. 568. It would appear that the Federal Government did not wish administrative costs of individual plans to be part of the per capita cost, so as to create the incentive to the individual plans to operate as efficiently as possible.

[32]This is different from other federal-provincial "shared cost" programs. For example, in the Canada Assistance Plan the Federal Government shares the approved costs with the Provincial Governments at a predetermined rate i.e., 50-50. In the Medical Care Act approved costs are averaged on a national basis. Because costs differ between provinces for similar health services and because costs change provincially at different rates the percentage of sharing costs between the Federal Government and the province varies over time.

A province may adopt any method it wishes of paying the providers of services, subject only to the proviso that "the tariff of authorized payments" is on a basis that ensures reasonable compensation for insured services rendered and "does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons."[33] The Act also tries to discourage the use of additional charges at the time of service by not making them costs which can be shared with the Federal Government.[34]

The administrative and financial aspects of the Federal Medical Care Act leave the provinces with substantial flexibility in introducing their own programs. As the Prime Minister said to the Federal-Provincial Conference on July 19 and 20, 1965, this framework serves as a basis for a "general federal-provincial understanding as to the nature of the health program which will make a federal fiscal contribution appropriate."[35] The Federal Government, as the social level and standard setter, has responded with efforts to unify the country in the field of health care by means of a fiscal mechanism.

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[33] Canada. Medical Care Act. Op. cit., Section 4(1)(b).

[34] Ibid., Section 5(4).

[35] Extract from statements by the Right Honourable L.B. Pearson, Prime Minister of Canada, at the Federal-Provincial Conference, Ottawa, July 19 and 20, 1965. Medicare and Health Services, The Federal Government's Role, p. 3.

CHAPTER III

ADMINISTRATION AND GENERAL POLICY OF PROVINCIAL HEALTH CARE PLANS

Administration

Date of Entry of Plan by Individual Provinces

One of the first major differences in the provincial plans has been the date of entry of each province. Originally the Medical Care Act was framed in the expectation that federal contributions to provincial plans would relate to the commencement of participating provincial plans as of July 1, 1967; however, because of overall considerations relating to broad economic policy the federal government specified that the provisions of the legislation would take effect on July 1, 1968.[1] Not all provinces became participating provinces as of July 1, 1968. The dates of entry of the individual provinces are listed in Table I.

Although all provinces will eventually be participants in the Federal Medical Care Act, the fact remains that for a large majority of Canadians the financial barrier to medical care has been delayed or still exists.[2] At the end of the conference of

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[1]Canada. Resume of Medical Care Legislation, op. cit., p. 1.

[2]This unfortunate situation, however, is not unusual in the implementation of Federal-Provincial Health and Welfare joint legislation. The general pattern has been for some provinces to participate from the beginning of a program and the others to enter

TABLE I

DATE OF ENTRY OF PROVINCIAL HEALTH INSURANCE PLANS

Province	Date of Entry
Saskatchewan	July 1, 1968
British Columbia	July 1, 1968
Manitoba	April 1, 1969
Nova Scotia	April 1, 1969
Newfoundland	April 1, 1969
Alberta	July 1, 1969
Ontario	October 1, 1969
	Date of Proposed Entry
Quebec	September 1, 1970
Prince Edward Island	December 1, 1970
New Brunswick	January 1, 1971

Health Ministers in April, 1967, Federal Minister of Health and Welfare Allan MacEachern expressed confidence that when the federal payments started on July 1, 1968 all 10 provinces would have qualifying plans.[3] This has not in fact taken place. The Royal Commission on Health Services found for the year 1961 that 53 percent of Canadians (10,675,000 persons) had health insurance

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later when the provincial governments concerned have decided that the time is opportune. This pattern was established with the first Old Age Pension Act passed in 1927, when only British Columbia participated from the beginning. Two provinces, Saskatchewan and Manitoba entered in 1928; Ontario and Alberta in 1929, Prince Edward Island in 1933; Nova Scotia in 1934; and Quebec and New Brunswick not until 1936. The Hospital Insurance and Diagnostic Services Act which was passed by Parliament in 1957 became effective July 1, 1958. Only five provinces initiated programs on that date. It was 1959 before programs were initiated in Ontario, Nova Scotia, New Brunswick and Prince Edward Island while Quebec did not begin its program until 1961.

[3] Canada. Health Ministers' Conference (April, 1967).

coverage while 47 percent (7,500,000 persons) did not have any insurance.[4] Table II provides a conservative estimate of the number of persons without coverage as of January 1, 1970.[5]

TABLE II

ESTIMATES OF THE NUMBER OF PERSONS THAT ARE NOT COVERED BY A HEALTH INSURANCE PLAN IN NON-PARTICIPATING PROVINCES

Province	Population[6]	No. of Persons Without Coverage	Percentage of Total Population
Quebec	6,004,000	2,161,440	36[7]
Prince Edward Island	110,000	62,000	58[8]
New Brunswick	623,000	280,350	45[8]
TOTAL	6,737,000	2,503,790	

Percentage of persons that do not have any coverage in non-participating provinces = 37%.

Reference to Table II indicates that approximately 2,503,790 persons or approximately 37 percent of the total population in the non-participating provinces (11.8% of the Canadian population) do not have any health care coverage.

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[4]Canada. Royal Commission on Health Services. Op. cit., p. 743.

[5]It should be noted that if all provinces were included in this calculation the percentage might be higher because even in participating provinces, as noted in Chapter II, coverage must be only 90 percent for the first two years and 95 percent thereafter.

[6]Canada, Dominion Bureau of Statistics. Population Estimate as of January 1, 1970. Population Bulletin (Ottawa: Queen's Printer, 1970).

[7]Quebec. Quebec Health Insurance Plan (Budget Speech, Quebec National Assembly April 29, 1969, Percentage for 1969).

[8]Canada. Social Security. Dept. of National Health and Welfare (Ottawa: Queen's Printer, 1969) estimated percentage for 1967.

Administrative Structures Devised by Various Provinces to Administer Health Insurance Plans

It was noted in Chapter II that the constitutional, fiscal and political structures in Canada have made the implementation of health and welfare programs in Canada highly complex. John S. Morgan has noted that,

> "Since the health and welfare programs have grown up, so to speak, out of social and political pressures of the changing situation, and are not developments of any predetermined plan of action, there is also a tendency for the administrative direction of particular programs to be placed in the hands of government departments or agencies that reflect the balance of power at the time of this establishment rather than in some pattern based on administrative logic."[9]

A similar situation existed in the United Kingdom until the Beveridge Report of 1942 took an overview of the results of a similar haphazard growth in Great Britain and set forth a comprehensive and logical basis of reorganization. "Even if his proposals were not all adopted and circumstances have changed the design, the need for some underlying consistency in organization was clearly established..."[10] Canada has not had a Beveridge Report and her political and constitutional situation has not facilitated such a logical arrangement of functions.

A comparison is made in Table III of the type of administrative vehicle selected by the individual provinces for health insurance

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[9] Barbara N. Rodgers, John Greene and John S. Morgan. Comparative Social Administration. Op. cit., p. 209.

[10] Ibid., p. 209.

with the type of organization selected to administer their individual hospital insurance and public health programs.

TABLE III

COMPARISON OF PROVINCIAL ADMINISTRATIVE STRUCTURES FOR HEALTH INSURANCE, HOSPITAL INSURANCE, PUBLIC HEALTH

Province	Health Insurance	Hospital[20] Insurance	Public Health
Alta.	Commission[11]	Departmental	Departmental
B.C.	Commission[12]	Departmental	Departmental
Man.	Commission[13]	Commission	Departmental
Nfld.	Commission[14]	Departmental	Departmental
N.S.	Commission[15]	Commission	Departmental
Ont.	Departmental[16]	Commission	Departmental
Sask.	Commission[17]	Departmental	Departmental
Que.	Commission[18]	Departmental	Departmental
N.B.	Departmental[19]	Departmental	Departmental
P.E.I.	Not Yet Announced	Commission	Departmental

[11]Alberta. The Alberta Health Care Insurance Act, Chapter 43 (Edmonton: Queen's Printer, 1969), Part I, Sec. 4(1).

[12]British Columbia. Medical Services Act, Chapter 24 (Victoria: Queen's Printer, 1967), Sec. 3(i).

[13]Manitoba. The Manitoba Medical Services Insurance Act (Winnipeg: Queen's Printer, 1967), Sec. 4(1). The Act specifies that this body is a Corporation; however, the Corporation meets the definition of a Commission in this thesis.

[14]Newfoundland. The Newfoundland Medical Care Insurance Act (St. John's: Queen's Printer, 1968), Sec. 4(1).

[15]Nova Scotia. Medical Care Insurance Act (Halifax: Queen's Printer, 1968), Sec. 4(1).

[16]Ontario. The Health Services Insurance Act (Toronto: Queen's Printer, 1969), Sec. 2.

[17]Saskatchewan. The Saskatchewan Medical Care Insurance Act (Regina: Queen's Printer, 1962), Sec. 3.

[18]Quebec. Quebec Health Insurance Board Act (Quebec City: Queen's Printer, 1969), Sec. 3. The Act specifies that the body is a Corporation; however, the Corporation meets the definition of a Commission in this thesis.

[19]Graham Clarkson, Deputy Minister of Health and Welfare, Fredericton, New Brunswick: Personal Communication.

[20]E.N. Stefanuk. "Comparison of Provincial Hospital Plans," Canadian Hospital (Vol. 47, No. 3, March 1970), pp. 44-45.

Table III indicates that while the commission is the dominant form of organization structure devised to administer health insurance plans,[21] the departmental structure has been mainly selected to administer the hospital insurance plans. Public health is totally organized on a departmental basis. It should be noted that New Brunswick is the only province which has been consistent in terms of the organization it has selected for all three programs. The provincial governments have decided to organize the public sector of the health delivery system with a variety of dissimilar administrative structures.[22] As

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[21] It is interesting to note that the Royal Commission on Health Services recommended a commission form of organization for health insurance. Royal Commission on Health Services, Vol. 1, op. cit., p. 20.

[22] It is interesting to note that the Royal Commission on Health Services recommended that a commission health insurance organization should also assume administration of the hospital insurance plan in the province.

> "Our recommendation that the provincial Health Services Commission should assume responsibility for the administration of the provincial hospital insurance plans will insure that within each province the development of all personal health services will take place within an administrative organization that minimizes duplication of services, that permits the development of integrated services and that is responsive to those who use and those who provide health services."

The Royal Commission on Health Services also recommended public health programs should not be included in the Health Services Commission with health insurance and hospital insurance.

> "It has been suggested, however, that, with one provincial administrative body charged with the organization of all personal health services within the program, this may have as its consequence the diversion of funds from one category of health services to another resulting in a reduction of the quality of care in the first area. With one organization responsible for administering all the funds, the budget for any one fund could prove to be inadequate."

Royal Commission on Health Services, Vol. II (Ottawa: Queen's Printer, 1965), p. 219.

noted previously, this has been in keeping with Canada's historical pattern. The question of whether this varied structure will minimize administration costs and provide a coordinated and integrated Health Care Delivery System is yet to be answered.

Intermediary Agencies

It was stated in Chapter II that the form of organization must be a public authority and yet intermediary agencies may be designated to carry out certain functions provided that the assessment and approval of individual accounts are handled by the public authority.[23] The number of provincial health insurance plans using intermediary agencies is noted in Table IV.

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[23]This was one of the major areas of dispute between the provinces and the federal government. According to the press, the Federal Minister of Health and Welfare stated at various times and in various ways that:

(1) Administration would be purely a provincial affair as long as a province "accepted responsibility."

(2) A province could integrate a doctor-sponsored plan into its program or even designate a private insurance company to be its agent, to collect premiums and make payments, but the assessment of claims and the determination of payments represent a crucial function that should be undertaken by a public authority.

(3) The claim of insurance people that, with respect to health insurance, they represent a non-profit organization is a matter that could be verified in a province proposing to use a private carrier.

Reportedly, the Federal Minister of Health and Welfare showed a marked lack of enthusiasm for seeking an amendment to the act whereby the federal government would share provincial administrative as well as operating costs. The Minister was said to have remarked that he did not think it likely that any province would want to have a mixture of public and private agencies providing medicare and added "the opinion is that a single agency is the least expensive."

"Public Administration One Item: Three Points Hold Up Medicare Pact," Toronto Globe and Mail, April 19, 1967.

TABLE IV

PROVINCIAL HEALTH INSURANCE PLANS USING INTERMEDIARY AGENCIES

Province	Intermediary Agencies Used	No. of Intermediary Agencies Used
Alta.	No	N/A
B.C.[24]	Yes	7
Man.[25]	Yes	1
Nfld.	No	N/A
N.S.[26]	Yes	1
Ont.[27]	Yes	40
Sask.[28]	Yes	2
Que.	No	N/A
N.B.	No	N/A
P.E.I.	Not Yet Announced	

Five provinces have selected to use intermediary agencies. The functions and powers of the intermediary agencies differ within and between provinces. These agencies cannot assess claims or determine the amount paid for these health services; however, these agencies may sell premiums, assess claims and determine the amount of payment for health services that are not insured services. The question of whether non-profit intermediary agencies would not only have a largely meaningless role but also would impede constructive

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[24]British Columbia. "A Brief Description of Benefits Provided." An Information Bulletin of the British Columbia Medical Plan (Victoria: British Columbia), p. 4.

[25]Manitoba. "Information Regarding Medical Insurance for Residents of Manitoba." An Information Bulletin of the Manitoba Health Services Insurance Corporation (November, 1969), p. 4.

[26]Nova Scotia. Medical Care Insurance Act. Memorandum of Agreement. Province of Nova Scotia and Maritime Medical Care Incorporated, op. cit., p. 15.

[27]Ontario. Ontario Health Services Plan. Information Pamphlet (Toronto, 1969).

[28]Saskatchewan. Saskatchewan Medical Care Insurance Commission. Annual Report, 1969, p. 14.

administration is yet to be answered.

Commission Membership Required by Statute

TABLE V

MEMBERSHIP REQUIRED BY PROVINCIAL STATUTE FOR PROVINCIAL HEALTH INSURANCE COMMISSIONS

Alta.[29]	Composed of five members appointed by the Lieutenant-Governor in Council.
B.C.[30]	Composed of not more than three members appointed by the Lieutenant-Governor in Council.
Man.[31]	Composed of not more than seven members appointed by the Lieutenant-Governor in Council and of whom two members must be selected out of six nominated by the Manitoba Medical Association.
Nfld.[32]	Composed of not less than five voting members appointed by the Lieutenant-Governor in Council and of whom two members must be selected out of five names submitted to the Minister by the Medical Association. There shall be two non-voting members who shall be the Deputy Minister of Health and the Executive Director of the Commission.
N.S.[33]	Composed of not fewer than five nor more than nine persons. At least two members must be members in good standing in Nova Scotia Medical Society.
Sask.[34]	Composed of not less than seven and not more than eleven. Deputy Minister of Health shall be an ex-officio non-voting member. Three members must be physicians agreed upon between the Lieutenant-Governor in Council and the College of Physicians and Surgeons, one of whom shall be a specialist, one a general practitioner and one a full-time staff member of the College of Medicine of the University of Saskatchewan. Two others may be physicians.

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[29]Alberta. The Alberta Health Care Insurance Act, op. cit., Part I, Sec. 4(1).

[30]British Columbia. Medical Services Act, op. cit., Chapter 24, Sec. 3(1).

[31]Manitoba. The Manitoba Medical Services Insurance Act, op. cit., Sec. 5(1).

[32]Newfoundland. The Newfoundland Medical Care Insurance Act, op. cit., Sec. 4(2), 4(3).

[33]Nova Scotia. Medical Care Insurance Act, op. cit., Sec. 4(1), 4(2).

[34]Saskatchewan. The Saskatchewan Medical Care Insurance Act, op. cit., Sec. 4.

TABLE V -- Continued

Que.[35]	Composed of twelve members. Two members are from bodies representing business, two members from bodies representing labour, one from health professions other than the medical profession, three physicians--one upon the recommendation of the association representing medical specialists, one upon the recommendation of the association representing the general practitioners, one upon joint recommendation of both medical associations. Three other members shall be officers of the government. President is appointed by the Lieutenant-Governor in Council; President has vote only in a tie.

It should be noted that Alberta and British Columbia do not designate specific types of individuals that by statute must be on the Commission. All other provinces specify that a certain number of physicians representing individual provincial medical associations or societies must be on the Commission. Quebec requires a much broader base.[36] The Royal Commission on Health Services concluded that membership on a health insurance commission should include "representation of the public, the health professions and Government." The question may be asked why the provinces (except Quebec) have not legislated the recommendations of the Royal Commission on Health Services. If the principle of broad representation can be accepted, it would seem that this should be spelled out in the statutes.

General Administrative Policy

Requirements for Eligibility

The presence or absence of compulsory registration and payment of premiums as a condition for participation in a

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[35] Quebec. Quebec Health Insurance Board Act, op. cit., Sec. 7.

[36] Royal Commission on Health Services, Vol. I, op. cit., p. 20.

health insurance plan is important, because it may impede or prevent an individual in need from entering the health care delivery system. The provinces have not legislated uniform requirements in this regard. The differentiating characteristics are summarized in Table VI and VII.

TABLE VI

REGISTRATION IN PROVINCIAL HEALTH INSURANCE PLANS

	Must Register To Be Eligible For Benefits	Must Register or Face Fine	Type of Penalty If Not Registered
Alta.[37]	No (only has to be resident)	Yes	Summary conviction not to exceed $100.
B.C.[38]	Yes	No	N/A
Man.[39]	No (only has to be resident)	No	N/A
Nfld.[40]	No (only has to establish residency)	No	N/A
N.S.[41]	Yes	No	N/A
Ont.[42]	Yes	No	N/A
Sask.[43]	Yes	Yes	Summary conviction not exceeding $25.
Que.	Details of Plan not yet announced.		
N.B.[44]	No (only has to be resident)	No	N/A
P.E.I.	Details of Plan not yet announced.		

[37]Alberta. The Alberta Health Care Insurance Act, op. cit., Sec. 19, Sec. 33(1), and Sec. 32(2).

[38]British Columbia. British Columbia Medical Plan, Rules and Regulations (Victoria: Queen's Printer, Division (1)"Subscriber").

[39]Manitoba. The Manitoba Health Services Insurance Act, op. cit., Sec. 21.

[40]Newfoundland. The Newfoundland Medical Care Insurance (Beneficiaries and Enquirer) Regulations (St.John's: Queen's Printer, 1968, Sec. 4.

[41]Nova Scotia. Medical Care Insurance Act, op. cit., Sec. 22(1).

[42]Ontario. The Health Services Insurance Act. 1968-69, op. cit., Sec. 6(1), Sec. 11(2), and Sec. 30(1).

[43]Saskatchewan. The Saskatchewan Medical Care Insurance Act, op. cit., Sec. 11(1), 11(2), and Sec. 12(1).

[44]New Brunswick Medical Services Act, op. cit., Sec. 1(a) and Sec. 1(g).

TABLE VII

PAYMENT OF PREMIUMS IN PROVINCIAL HEALTH INSURANCE PLANS

	Must Pay Premium To Be Eligible For Benefits	Must Pay Premium or Face Fine	Type of Penalty
Alta.[45]	No	Yes	Summary Conviction of $25. plus premium or part thereof.
B.C.[46]	Yes	No	N/A
Man.[47]	No	Yes	Agent-Summary conviction of not more than $500.plus portion of premium not paid but due. Individual-Summary conviction of not more than $200. plus portion of premium not paid but due.
Nfld.	N/A	No premium in this plan	N/A
N.S.	N/A	No premium in this plan	N/A
Ont.[48]	Yes	Only those designated in a mandatory group or collector's group.	Collector, designated agent or employer is liable to a summary conviction of not less than $2000. plus premiums not paid.
Sask.[49]	Yes	Yes	Summary conviction not exceeding $25. plus the court shall order payment of premium or part thereof.
Que.	N/A	No premium in this plan	N/A
N.B.	N/A	No premium in this plan	N/A
P.E.I.	Details of Plan not yet announced.		N/A

[45]Alberta. The Health Insurance Premiums Act (Edmonton: Queen's Printer, 1969), Sec. 8(3) and Sec. 9(1).

[46]British Columbia. British Columbia Medical Plan, Rules and Regulations, op. cit., Division (1) "Subscriber."

[47]Manitoba. The Manitoba Health Services Insurance Act, op.cit., Sec. 31 and Sec. 35.

[48]Ontario. The Health Services Insurance Act, 1968-69, op.cit., Sec. 7(2). Premium payment is compulsory for those designated as a mandatory or collector's group.

[49]Saskatchewan. The Saskatchewan Medical Care Insurance Act, op. cit., Sec. 12, 39 and 40(i).

It should be noted that four provinces make residence the only requirement for eligibility of benefits. Four other provinces make registration a requirement but only in Alberta and Saskatchewan is there provision in the legislation for a fine if registration is not completed.[50] In Table VII it is indicated that five provinces have chosen to finance their health insurance plans by using other means than a premium system. Two of the provinces (Manitoba and Alberta) require a premium payment but do not make payments a mandatory requirement before an individual will be eligible for benefits. In Saskatchewan, Ontario and British Columbia premiums have to be paid before an individual is eligible for benefits. In the provinces that have used the premium system only in British Columbia is there no legislation regarding fines if the premiums are not paid. This is offset by the fact that no benefits are issued to the individual if he does not pay the premium. Ontario's plan is similar to that of British Columbia for individuals other than those in a mandatory or collector's group. For those in a mandatory or collector's group a fine is provided in the legislation.

The question of whether or not these requirements prevent or impede a person in need from obtaining health services will only be answered when information is available after the plans are in operation for a number of years. One may question, however, which of the plans is the least costly to administer.

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[50] How vigorously the provinces enforce this legislation has yet to be indicated.

Limitations on Private Insurance Coverage Under Health Insurance Plans

The Royal Commission on Health Services noted in 1961 that 9,625,000 Canadians had health insurance coverage provided by agencies outside of the government.[51] The continuing role of these agencies in the provision of health insurance after participation by all the provinces of Canada in the Federal Medical Care Act can only be completely determined by future events. These agencies may be able to provide coverage for services that are not benefits of the provincial health insurance plans.[52] This will depend on whether the provincial health insurance plans expend their coverage in these services. The role of the private sector in the provision of health insurance may be partially determined by noting the restrictions that have been set out in the various provincial health insurance acts for these agencies (see Table VIII).

TABLE VIII

RESTRICTIONS ON PRIVATE SECTOR IN THE PROVISION OF HEALTH INSURANCE

	Restriction	Comment
Alta.[53]	Yes	The Act stipulates that an insurer shall not issue or renew a contract which duplicates the benefits provided by the Plan; however, an insurer may issue contracts to indemnify costs over and above the benefits payable by the Commission for insured services rendered outside Alberta and payable to chiropractic, osteopathic, podiatric, and optometric services.

[51] This generally includes commercial insurance and prepayment plans. Royal Commission on Health Services, Vol. I, op. cit., p. 727.

[52] See section on coverage of benefits on page 44.

[53] Alberta. The Alberta Health Care Insurance Act, op. cit., Sec. 29(2),(3),(4). The Alberta Health Care Insurance Regulations, op. cit., Sec. 18.

TABLE VIII -- Continued

	Restriction	Comment
B.C.[54]	Yes	The Act stipulates that an insurer may not sell any of the benefits of the plan unless he is a certified carrier; however, in selling the benefits under the Plan the carrier only acts in an agency relationship with the provincial plan. No unapproved carrier or insurer may market benefits of the plan. The approved carriers may market additional coverage separately or in addition; however, premiums collected on behalf of the plan must be remitted to the plan. Approved carriers and the plan are not liable for any excess charges over and above those covered by the plan.
Man.[55]	Yes	The Act prohibits an insurer from providing coverage for services that are benefits under the plan. Benefits that are not provided by the plan may be sold.
Nfld.	No	No prohibition in legislation against private carriers providing coverage for health services that are insured services under the plan.
N.S.	No	Same as above.
Ont.[56]	Yes	The Act provides that as of Oct. 1, 1969 no persons shall issue or renew a contract of insurance for the payment of all or any part of the cost of insured health services performed in Ontario and received by any person eligible to become an insured person under the Act.
Sask.[57]	Yes	The Act provides that an approved health agency may sell coverage for services that are or are not benefits of the plan.
Que.	Details of the plan not yet announced.	
N.B.	No	No prohibition in legislation against private carriers providing coverage for health services that are insured services under the plan.
P.E.I.	Details of the plan not yet announced.	

[54]British Columbia. Medical Grant Act, op. cit., Sec. 8 Medical Services Act Regulations, Sec. 3.12, 3.13, 5.11, 9.05.

[55]Manitoba. The Health Services Insurance Act, op. cit., Sec. 48(1) and (5).

[56]Ontario. The Health Services Insurance Act, op. cit., Sec.25(1).

[57]Saskatchewan. The Saskatchewan Medical Care Insurance Act, op. cit., Sec. 19.

In the provinces of Alberta, British Columbia, Manitoba and Ontario, an individual may obtain coverage for health benefits only from the official public agency or approved intermediary agencies. It was indicated in the previous section that British Columbia and in a restricted sense Ontario (only individuals not in a mandatory or collector's group), do not have penalties if premiums are not paid. It can be concluded that in the provinces of British Columbia and for individuals in Ontario the only alternative to government sponsored health insurance is not to have health insurance.

The Portability Features of Health Care Plans

Period Required Before an Individual is Eligible for Health Insurance Benefits

It was noted in Chapter II that in order for a province to qualify for participation in the Federal Medical Care Act one of the main administrative requirements was that the plans had to provide for portability--

> "...the plan does not impose any minimum period of residence in the province or any waiting period in excess of three months before persons who are now or become residents of the province are eligible for or entitled to insured services."[58]

The variety of procedures the provinces have employed is summarized in Table IX.

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[58] Canada. The Federal Medical Care Act, op. cit., Sec. 4(1)(d).

TABLE IX

PERIOD REQUIRED BEFORE AN INDIVIDUAL IS ELIGIBLE FOR HEALTH INSURANCE BENEFITS

	Period Required for an Individual Leaving a Participating Province	Period Required for an Individual Leaving a Non-Participating Province
Alta.[59]	None (residence only)	None (residence only)
B.C.[60]	Coverage effective the day after termination of previous coverage provided application is made within one month of the termination of former coverage.	Coverage effective on the first day of the second calendar month following the month in which the individual's application is accepted by the carrier.
Man.[61]	3 months.	3 months.
Nfld.[62]	3 months.	None (residence only)
N.S.[63]	3 months.	3 months.
Ont.[64]	3 months for an individual 1 month for a mandatory or collector's group.	3 months for an individual 1 month for a mandatory or collector's group.
Sask.[65]	3 months.	3 months.
Que.	Not yet announced.	Not yet announced.
N.B.	Not yet announced.	Not yet announced.
P.E.I.	Not yet announced.	Not yet announced.

In only the provinces of British Columbia and Newfoundland are there procedural differences for individuals emigrating from a

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[59] Alberta. The Alberta Health Care Insurance Regulations, op. cit., Sec. 16(1).

[60] British Columbia. "A Brief Description of Benefits Provided," op. cit., p. 4.

[61] Manitoba. "Information Regarding Medical Insurance for Residents of Manitoba," op. cit., p. 4.

[62] Newfoundland. The Newfoundland Medical Care Insurance (Beneficiaries and Enquirer) Regulations (St. John's: Queen's Printer, 1969), Sec. 5.

[63] Nova Scotia. Medical Services Insurance. Information Pamphlet.

[64] Ontario. The Health Insurance Services Act, 1967, op. cit., Sec. 7(2).

[65] Saskatchewan. The Saskatchewan Medical Care Insurance Annual Report, 1968 (Regina: Saskatchewan), p. 18.

participating or non-participating province. Generally speaking, if a person emigrates from a participating province to British Columbia the waiting period is three months. Alberta and Ontario provide an exception to the three month waiting period. Table IX assumes that all procedures regarding premiums and registration are completed.

Waiting Periods Required by Health Care Plans

TABLE X

WAITING PERIODS REQUIRED BY PROVINCIAL HOSPITAL AND HEALTH INSURANCE PLANS[66]

	Provincial Health Insurance Plan	Provincial Hospital Insurance Plan[67]
Alta.	None	None
B.C.	On termination of coverage of prior province.	3 months
Man.	3 months	3 months
Nfld.	3 months	3 months
N.S.	3 months	3 months
Ont.	3 months individual 1 month if entering a mandatory group	3 months
Sask.	3 months	3 months
Que.	Not yet announced.	3 months
N.B.	Not yet announced.	3 months
P.E.I.	Not yet announced.	3 months

It would appear that except for the provinces of Ontario and British Columbia a consistent policy of waiting period for both Provincial Health Insurance and Hospital Plans has been maintained. During research no explanation was encountered as to why the provinces of British Columbia and Ontario were not consistent in both plans.

[66] It should be noted that the above presentation is only for individual's emigrating from participating provinces.

[67] E.N. Stefanuk, "Comparison of Provincial Hospital Plans," Canadian Hospital, op. cit., pp. 44-45.

Extension of Coverage After Loss of Residence

TABLE XI

EXTENSION OF COVERAGE PROVIDED BY PROVINCIAL HEALTH INSURANCE PROGRAMS AFTER LOSS OF RESIDENCE[68]

	Extension of Coverage Provided for an Individual Moving to a Participating Province	Extension of Coverage Provided for an Individual Moving to a Non-Participating Province
Alta.[69]	Remains entitled to benefits while travelling not to exceed one month and during the waiting period prescribed under the plan where residence is being made.	Remains entitled to benefits for three months.
B.C.[70]	Remains entitled to benefits for three months.	Remains entitled to benefits for three months plus travelling time not to exceed 1 month.
Man.[71]	Remains entitled to benefits for three months and travelling time not to exceed one month if approval given. Also completion of treatment if care is started before loss of residence.	Same as participating province.
Nfld.[72]	Entitled to benefits for three months plus travelling time.	Entitled to benefits for three months.
N.S.[73]	Entitled to benefits for three months plus travelling time.	Entitled to benefits for three months.
Ont.[74]	Entitled to benefits as long as it takes for resident province to assume coverage or after four months whichever occurs first.	Entitled to benefits for four months.

[68] A similar analysis could be performed if loss of residence occurred to a country outside Canada.

[69] Alberta. The Alberta Health Care Insurance Act, op. cit., Sec. 20(1)&(2).

[70] British Columbia. Medical Service Act Regulations, op. cit., 7:02.

[71] Manitoba. "Information Regarding Medical Insurance for Residents of Manitoba," op. cit., 4(g).

[72] Newfoundland. The Newfoundland Medical Care Insurance (Beneficiaries & Enquirer) Regulations, op. cit., Sec. 5(1) and (2).

[73] Nova Scotia. Medical Services Insurance, op. cit.

[74] Ontario. The Health Services Insurance Act, 1968-69, op. cit., Sec. 16(a)(b).

TABLE XI -- Continued

	Extension of Coverage Provided for an Individual Moving to a Participating Province	Extension of Coverage Provided for an Individual Moving to a Non-Participating Province
Sask.	Entitled to benefits for three months.	Entitled to benefits for three months.
Que.	Not yet announced.	Not yet announced.
N.B.	Not yet announced.	Not yet announced.
P.E.I.	Not yet announced.	Not yet announced.

It should be noted in Table XI that all provinces except Ontario and Alberta provide at least three months extension of coverage on loss of residence. In Ontario and Alberta loss of coverage takes place whenever a person becomes eligible for coverage in a new province of residence. For persons moving to a province which is a participant in the Federal Medical Care Act only British Columbia, Ontario and Saskatchewan do not provide travelling time. In contrast, for persons moving to provinces that are not participating in the Federal Medical Care Act only British Columbia and Manitoba provide travelling time. Ontario does not provide travelling time but coverage is extended for four months.

No published material was found justifying the existence of travelling time and waiting periods.[75] It would seem, however, that the provinces have tried to avoid health costs incurred by individuals

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[75]Many provinces do not have waiting periods for specific groups of people. For example, in Saskatchewan, landed immigrants from outside Canada are eligible to participate any time following establishment of residence.

crossing provincial boundaries solely for the purpose of obtaining health benefits. One could question whether this mechanism is economically sound. For example, the British Health Services does not have any waiting period. It believes that it is more efficient not to have a waiting period than to have an agency monitoring patient flow in and out of the service.

Out of Province Benefits Provided by Health Care Plans

TABLE XII

OUT OF PROVINCE BENEFITS PROVIDED BY HEALTH AND HOSPITAL INSURANCE PLANS

	Provincial Health Insurance Plan	Provincial Hospital Insurance Plan[76]
Alta.[77]	Remains entitled to benefits as if still in province.	No restriction on out-of-province benefits after 1969.
B.C.[78]	Remains entitled to benefits as if still in province. This is limited to illness or injury that is unexpected. On elective basis approval is needed.	In-patient--six months approval needed if further stay required. Referral if approved by Deputy Minister.
Man.[79]	Remains entitled to benefits as if in province for one year. After one year coverage continues if given approval.	Rate approved by hospital insurance plan if the province in which hospitalization takes place decrees no time limit.

[76] E.N. Stefanuk, "Comparison of Provincial Hospital Plans," op. cit., pp. 46-47.

[77] Alberta. The Alberta Health Care Insurance Act, op. cit., Sec. 20(3).

[78] British Columbia, "A Brief Description of Benefits Provided," op. cit., p. 4.

[79] Manitoba, "Information Regarding Medical Insurance for Residents of Manitoba," Manitoba Health Services Insurance Corporation, Information Bulletin, November 1969, 4(a).

TABLE XII -- Continued

	Provincial Health Insurance Plan	Provincial Hospital Insurance Plan
Nfld.[80]	Remains entitled to benefits during temporary absence.	Same benefits as provided in the province.
N.S.[81]	Remains entitled to benefits during temporary absence.	Remains entitled to benefits if it is an emergency and approved by Commission.
Ont.[82]	Remains entitled to benefits as per plan or amount actually paid whichever is the lesser.	Full rate in other Canadian provinces less any co-insurance or capital charges made.
Sask.[83]	Remains entitled to benefits. The Commission may pay extra fee if approved by Committee of Physicians.	Payment for any period of in-patient standard ward care at the per diem rates established by the province having jurisdiction.
Que.	Details not yet available.	Plan pays full approved rates for approved services provided in other provinces.
N.B.	Details not yet available.	Remains entitled to benefits for services resulting from a sudden attack of illness or injury for a period not exceeding 12 months and approved services not available in province.
P.E.I.	Details not yet available.	Emergency in-patient services if prior approval is obtained.

It should be noted in Table XII that in six of the provinces providing health insurance, benefits are payable on the amounts as would be assessed if the resident required treatment inside the

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[80]Newfoundland. "Newfoundland Medical Care Plan" An Information Bulletin Newfoundland Medical Care Commission (St. John's: Newfoundland, No. 6).

[81]Nova Scotia. Medical Care Insurance Act, op. cit.

[82]Ontario. The Health Services Insurance Act, 1968-69, op. cit., Sec. 19(2).

[83]Saskatchewan, Annual Report 1968, op. cit., p. 13.

province. Only in the Province of Ontario is there a notable difference. Saskatchewan makes provision if approval is given for an extra fee. In comparison it should be noted that in the individual Provincial Hospital Plans five provinces (British Columbia, Newfoundland, Nova Scotia, New Brunswick, P.E.I.) pay benefits in amounts as if the individual required treatment in amounts approved by the Hospital Insurance Plan of the province in which hospitalization occurs. Four of the six provinces that are participants in the Federal Medical Care Act have a consistent policy of restricting payments in both health insurance and hospital insurance to amounts as would be assessed if the resident required treatment inside the province.

Information as to why the provinces have not established the same uniform procedures in both plans could not be found. One may question the efficiency and effectiveness of the present system. If agreed standardized procedures could be formulated a number of procedures now being performed might be eliminated. For example, the physician and in some cases the Deputy Minister of Health must approve services to be received by a resident entering another province. Could not this function be eliminated, thus leaving these individuals more time to devote to areas that have a higher benefit-cost ratio? e.g., clinical medicine or high level administrative policy. A standardized and simple system would facilitate the consumer's understanding of services and would also decrease the amount of "red tape" necessary for entrance into the health care delivery system. The question of whether or not restricting the amounts payable on health benefits restricts an individual from seeking health services outside

a province can only be answered after the health insurance plans have been in operation for a number of years.

Health Insurance Benefits in Provincial Health Insurance Plans

It was noted in Chapter II that in order for a province to participate in the Federal Medical Care Act it must make available on uniform terms and conditions insured services that are "medically required."[84] There are, however, a number of health services that are not included in this definition. Some of these services are listed below:

1) Prescribed drugs sold only at retail outlets.
2) Services of a private duty nurse, chiropractors, osteopaths, and optometrists.
3) Dental services.
4) Prosthetic Services
5) Naturopathy.

In 1966 health expenditures for these services represented 92.5% of the total amount spent on physician services.

TABLE XIII

EXPENDITURES ON HEALTH SERVICES IN 1966 IN CANADA[85]

Prescribed Drugs	$190,000,000
Private Duty Nurses, Chiropractors,etc.	193,000,000
Dentists' Services	177,000,000
Total	$560,000,000
Physician Services	605,000,000
Total as a percentage of physician services	92.5%

[84]The Royal Commission on Health Services defines "Comprehensive" as all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other services can provide.

[85]Eric Hanson, Task Force Reports on the Cost of Health Services in Canada (Edmonton: Queen's Printer 1969) #3, Table C-18, p. 414.

There are other health services that are not insured services according to the Federal Medical Care Act, e.g., examinations required by third parties. Of particular mention are those services provided under any other act of Parliament of Canada or any provincial law relating to workmen's compensation. Two important groups here are those who are mentally ill and those who have tuberculosis. The Report of the Commission of Inquiry on Health and Social Welfare in Quebec has stated that this

> "...will prevent the provinces concerned from achieving as complete an integration as possible of care plans and greater unification of medical care insurance plans. In this connection, past experience with the federal Hospital Insurance and Diagnostic Services Act showed how prejudicial this exclusion of certain groups of persons from the field of application of a medical care dispensation could be. In effect, the exclusion of the mentally ill and tuberculosis patients from the act has helped perpetuate the program isolation of these patients at two levels: administrative structures and treatment."[86]

A provincial health insurance plan may provide these services as health benefits; however, they will not qualify for financial assistance from the Federal Government under the Federal Medical Care Act. Despite this disadvantage, some provinces have decided to provide these items as benefits under their plans. A partial review will be made of a certain number of these services.

Private Nursing

The only province that provides any coverage for nursing

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[86]Prescribed drugs include all pharmaceuticals purchased on a physician's prescription from retail outlets, exclude drugs prescribed in hospitals, institutions other than hospitals, e.g., homes for the aged. Quebec. Report of the Commission of Inquiry on Health and Welfare, op. cit., p. 186.

services under its Health Insurance Plan is the Province of British Columbia.[87] The following benefits are provided:

1) Canadian Red Cross Society--Payment shall be made at the rate of $2.00 per office service, $4.00 per house call, for services rendered under the instructions of a physician, or for treatment of minor injuries at outposts approved by the commission. No benefits payable outside the province.

2) Special Nursing--Payment shall be made to a maximum of $40.00 per year under instructions of physicians. No benefits payable outside the province.

3) Victorian Order of Nurses--Payment shall be made at the rate of $2.00 net per visit to a maximum of $40.00 per year acting under the instructions of a physician. No benefits payable outside the province.

It should be noted that in other provinces private duty nursing similar to the above types of health services are provided and funded by other Government auspices.[88] British Columbia is the only province which includes payment of benefits under their Health Insurance Program.[89]

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[87] British Columbia. "A Brief Description of Benefits Provided," op. cit., p. 2-3.

[88] For example: The City of Edmonton gives the Victorian Order of Nurses a yearly grant to provide post-natal care for six weeks at no charge to the patient.

[89] It is interesting to note that the Task Force Report recommended:

> "That medical care insurance plans should cover the services of allied medical personnel working under the direction of practising physicians, such as public health nurses, social workers...etc."

Task Force Reports on the Cost of Health Services in Canada, No. 3, op. cit., Recommendation 25, p. 178.

Chiropractors, Osteopaths, and Naturopaths

The coverage of the services rendered under the above heading is set out in Table XIV.

TABLE XIV

COMPARISON OF CHIROPRACTIC, NATUROPATHY, AND OSTEOPATHY HEALTH BENEFITS IN PROVINCIAL HEALTH INSURANCE PLANS

	Chiropractic	Naturopathy	Osteopathy
Alta.[90]	Benefits payable are actual charges not exceeding $5. per visit and not exceeding $10. for one X-Ray for a particular disability and these benefits subject to a total of $100. per benefit period for any resident and his dependents.	No coverage.	Benefits payable are actual charges but not exceeding $4. per visit. Benefits are limited to $100. per benefit period for resident and his dependents.
B.C.[91]	Services of Chiropractic up to $50. per patient in any one year and to a maximum of $100. in any one year per contract, but there shall be no payment for X-Ray services.	Services of Naturopathic physicians not to exceed $50. per patient in any one year and to a maximum of $100 in any one year per contract.	Services that are medically required except those out of province.
Man.[92]	Benefits payable up to $50. per single person; $100. for a family of up to 3 persons and $150. for larger families.	No coverage.	No coverage.

[90] Alberta. The Alberta Health Care Insurance Regulations, op. cit., Sec. 6(1) and (2) and Sec. 7(1), (2) and (3).

[91] British Columbia. "A Brief Description of Benefits Provided," op. cit., pp. 2-3.

[92] Manitoba. "Information Regarding Medical Insurance for Residents of Manitoba," op. cit., 3(a).

TABLE XIV -- Continued

	Chiropractic	Naturopathy	Osteopathy
Nfld.	No coverage.	No coverage.	No coverage.
N.S.	No coverage.	No coverage.	No coverage.
Sask.	No coverage.	No coverage.	No coverage.
Que.	Details not announced.		
N.B.	Details not announced.		
P.E.I.	Details not announced.		

Table XIV indicates that only three provinces provide chiropractic benefits in their health insurance plans. However, these provinces limit the amount of benefits payable. The Province of British Columbia is the only province in which payments are made for naturopathic services. Osteopathic services are given coverage under the Alberta and British Columbia plans. Alberta has placed an upper limit on total payments while British Columbia does not have restrictions other than that payments will not be made for services rendered outside of the province.

A listing of the number of above practitioners practising in individuals provinces is made in Table XV. Also indicated are those provinces that provide coverage. An analysis of Table XV indicates that there is a large number of chiropractors, naturopaths and osteopaths practising in provinces where there is no coverage for these services.

TABLE XV

THE NUMBER OF CHIROPRACTORS, NATUROPATHS, AND OSTEOPATHS PRACTISING IN EACH PROVINCE AND A LISTING OF THOSE PROVINCES THAT PROVIDE COVERAGE[93]

	Chiropractic		Naturopathy		Osteopathy	
	No. of Practitioners	Health Ins. Coverage Provided	No. of Practitioners	Health Ins. Coverage Provided	No. of Practitioners	Health Ins. Coverage Provided
Alta.	121	Yes	18	No	3	Yes
B.C.	148	Yes	31	Yes	10	Yes
Man.	42	Yes	15	No	0	No
Nfld.	1	No	0	No	0	No
N.S.	20	No	2	No	3	No
Ont.	450	No	168	No	74	No
Sask.	36	No	3	No	2	No
Que.	240	Not yet announced	6	Not yet announced	7	Not yet announced
N.B.	14	Not yet announced	0	Not yet announced	2	Not yet announced
P.E.I.	1	Not yet announced	0	Not yet announced	0	Not yet announced
	1073		243		105	

Optometry

A similar analysis for Optometrists is presented in Table XVI.

[93]Figures for the number of practitioners in each province are for the year 1962. Unfortunately, no up-to-date figures could be found. Royal Commission on Health Services. "Study of Chiropractors, Osteopaths, and Naturopaths," Donald L. Mills (Ottawa: Queen's Printer, 1966), p. 71, Table III-I.

TABLE XVI

PRACTISING OPTOMETRISTS AND OPTOMETRIC HEALTH BENEFITS IN HEALTH INSURANCE PLANS

	Optometrists[99]	Coverage
Alta.[94]	112	Limited to refraction of the eyes for the fitting of eye glasses. Payment not more than $10. each benefit. Adults are allowed one benefit every two years. Children (under 18) once each year.
B.C.[95]	141	For tests of visual acuity only of a subscriber and his dependents. There can be no more than one such payment made per patient per year.
Man.[96]	60	For persons under 21, one eye examination and prescription each year. For persons between 21 and 39 one every three years. For persons over 39 one every two years.
Nfld.	6	No coverage.
N.S.[97]	38	No coverage.
Ont.	533	Examination of the eyes for the purpose of determining a requirement for corrective lenses. Limit to $10.
Sask.[98]	70	Eye examination to determine refractive error. Unless special medical factors are present the frequency of examinations is limited to one each year up to age 17, one every three years between the ages 17 and 46 and one every two years over the age of 46.
Que.	420	Details not yet available.
N.B.	44	Details not yet available.
P.E.I.	--	Details not yet available.

[94] Alberta. The Alberta Health Care Insurance Regulations, op. cit., Sec. 5(1) and (2).

[95] British Columbia. "A Brief Description of Benefits Provided," op. cit., p. 2.

[96] Manitoba. "Information Regarding Medical Insurance for Residents of Manitoba," op. cit., 3(a).

[97] Nova Scotia. Medical Services Insurance, op. cit.

[98] Saskatchewan. Annual Report, 1968, op. cit., p. 14.

[99] Royal Commission on Health Services, Vol. 1, op. cit., p. 291. Figures are for 1961.

Table XVI indicates that of the seven provinces that are now participants in the Federal Medical Care Act only Newfoundland and Nova Scotia have no coverage for optometric services. All provinces that provide benefits have a limit both in amount (except British Columbia) and in time between allowable benefits. British Columbia and Ontario are the only provinces that do not single out certain segments of the population by age to allow frequency of benefits over time.

In this section it has been shown that benefits for chiropractic, optometric, etc., services are available in some provinces and are not available in other provinces. In those provinces that provide these benefits there is no interprovincial consistency as to type and amount of coverage. The data also indicate that while there are a large number of these practitioners rendering services in participating provinces, the services are not always provided as benefits under provincial plans. The above situation results basically from two complex problems in this area.

(1) The medical profession and these practitioners (chiropractors, optometrists, etc.) disagree on the medical usefulness of the latter's services. The medical profession has not given full recognition to these practitioners for some of the following reasons.

"According to the medically qualified ophthalmologist, however, anyone who requires an eye examination should be examined by a physician because many symptoms of serious general disease

can be revealed in the eye and the optometrist is not qualified to recognize these."[100]

"Such groups lack appreciation of their own limitations and tend to apply their concepts beyond their knowledge and abilities, and under such circumstances constitute a distinct threat to life and limb."[101]

The problem has now, however, taken on a new dimension. Some of the provincial governments have decided to assume some of the financial responsibility for these health services. If it can be accepted that one of the goals of the provincial government is to provide beneficial services to its populace, and the medical profession's assessment of the situation is correct, it would seem that there is a conflict between the actions of the provincial government and its goals. Research should be conducted to determine to what extent the provincial governments are financing a medically useful service.

(2) It was noted prior that if a province provides these services as benefits it must assume 100% of the costs. Some provinces, e.g., Maritimes, do not have the fiscal capacity to provide these services. As a result, some Canadians are covered for certain health services while others are not.

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[100] Royal Commission on Health Services, Vol. 1, op. cit., p. 290.

[101] The College of Physicians and Surgeons of Ontario, Brief Submitted to the Royal Commission on Health Services, May, 1962.

The Royal Commission on Health Services has noted that there is a wide variation in the distribution (practitioner/population per province ratio) of Optometrists, Chiropractors, etc., in Canada.[102] It cannot be concluded from the data in this thesis that there is a shortage of these health personnel; however, a question may arise as to what effect the provision of health insurance coverage for these services in some provinces and not in others will have on the future distribution of new graduates in these professions. Health insurance coverage guarantees the payment of fees. One might expect that the provision of health insurance coverage will create an economic incentive for these individuals to locate their practices in provinces providing coverage under a provincial plan. Donald Mills notes in this regard,

> "Approximately one half of all practitioners (but proportionately more chiropractors) reported this to be a very or fairly important influence (proportionately more chiropractors), and many others reported that it was a less important influence, but an influence nonetheless. Generally speaking then, it appears that of the economic factors examined, income expectation was ostensibly salient in the vocational choice process."[103]

If research shows that these health personnel offer a useful medical service, then Canadians across the Dominion are entitled to equal access to these services.

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[102] Royal Commission on Health Services, Vol. II, op. cit., p.72. Royal Commission on Health Services Study of Chiropractors, Osteopaths, and Naturopaths, op. cit., p. 19.

[103] Ibid., p. 99.

CHAPTER IV

ECONOMIC STRUCTURE OF HEALTH CARE INSURANCE IN CANADA

General Background

"Our recommendations are such that we wish to speed up the day when all have access to health services that will enable them to make their contribution to Canada's welfare. Low incomes and poor health have been too closely associated for us to ignore the adverse effects on income distribution of chronic illness and disability. Expenditures on good health may well be as efficient a device for equalizing the distribution of income as any subsidy can possibly be. Nor is the cost of the best possible health care overwhelming, and Canada has the resources--let there be no mistake to that--and the competence to implement a comprehensive health services program for all her people."[1]

Professor Eric J. Hanson[2] has estimated that by 1981 government expenditures on health will be 8.04 percent of the Gross National Product of Canada. In 1968 this percentage was 4.56. He further predicts that government expenditures on medical, dental and allied services will rise from .31 percent of Gross National Product in 1968 to 2.29 percent of Gross National Product in 1981. This will be a significant change in our fiscal priorities from a private investment to a public investment in the health industry.

Total Costs of Health Insurance

For many years economists, politicians, commissions, etc.,

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[1] Royal Commission on Health Services, Vol. 1, op. cit., p. 857.

[2] Eric J. Hanson. Task Force Reports on the Cost of Health Services in Canada, op. cit., p. 443, Table 1-4.

have been trying to estimate the economic impact of financing physician services under the public sector. The estimates have been as varied as the number of people trying to make them. No estimates will be made in this study; however, an analysis of previous health insurance costs may provide some indication of future costs. K.C. Charron[3] in a study of health insurance systems produced the following (Table XVII).

TABLE XVII

ESTIMATED EXPENDITURES ON PHYSICIAN SERVICES, INCLUDING PHYSICIAN'S SERVICES IN HOSPITALS AS PERCENTAGES OF GROSS NATIONAL PRODUCT AT MARKET PRICES, YEARS 1953 AND 1961

Country	Percent of GNP in 1953	Percent of GNP in 1961
Canada	.70	1.04
United States	.94	1.33
New Zealand	.79	.78
United Kingdom	.58	.63
France	.63	.86
Norway	.62	.71
Netherlands	.62	.88

Charron concluded from the above data that,

> "...the five nations in which increases were less pronounced were the five that had government-sponsored insurance plans covering at least some physicians' services."[4]

As yet Canada has not had sufficient experience in the public provision of health insurance to provide actual costs. However, it is interesting to note the changes in health costs that took place in Saskatchewan after its inception of public health insurance in 1962.

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[3] K.C. Charron. Health Services, Health Insurance, and Their Inter-relationships, op. cit., p. 188.

[4] Ibid., p. 194. It should be noted, however, that this does not mean that these countries delivered the same quality and quantity of health services.

The province's per capita expenditures on physicians' services rose from 16.87 in 1962 to 26.06 in 1963.[5] These expenditures on physicians' services rose over the national average for the first time and rated third highest in the Dominion. In 1965, however, Saskatchewan's per capita expenditures on physicians' services dropped below the national average, and ranked fifth highest in the Dominion. It is uncertain as to whether the changes that took place in Saskatchewan are an indication of future health costs on a national scale.

Financing Health Insurance in Canada

It was noted in Chapter II that a province may finance its health insurance plan in any manner it desires. The provinces have taken advantage of this flexibility. The methods used to finance health insurance and hospital insurance are noted in Table XVIII.

It is evident from Table XVIII that the methods of financing are as varied as the types of organizations used to administer the plans. Three provinces have elected to use premiums as the sole method of financing health insurance. Manitoba and Saskatchewan use a combination of general revenue and premiums.[6] In only four provinces is there a similar method used to finance both plans. It is interesting to note that in the provinces of Saskatchewan and Manitoba premiums for both plans are collected jointly under one mechanism. Premium collections for health and hospital insurance in Ontario are made by separate agencies.

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[5] Department of National Health and Welfare. Earnings of Physician's in Canada, 1957-1965, p. 45.

[6] The Saskatchewan Health Insurance Plan notes that for the year ended December 31, 1969 premiums accounted for 19.81% of total receipts. Saskatchewan Medical Care Insurance Commission, op.cit., 1969.

TABLE XVIII

METHODS USED FOR FINANCING PROVINCIAL HEALTH INSURANCE AND HOSPITAL INSURANCE PLANS

	Health Insurance	Hospital Insurance[16]
Alta.[7]	Premium	General Revenue & Property Tax[17]
B.C.[8]	Premium	General Revenue
Man.[9]	Premium plus General Revenue	Premium plus General Revenue
Nfld.[10]	General Revenue	General Revenue
N.S.[11]	General Revenue	General Revenue + 7% Sales Tax
Ont.[12]	Premium	Premium plus General Revenue
Sask.[13]	Premium plus General Revenue	Premium plus General Revenue
Que.[14]	Personal plus Corporation Tax	General Revenue
N.B.[15]	General Revenue	General Revenue
P.E.I.	Details not yet announced	General Revenue

[7]Alberta. The Health Insurance Premiums Regulations, Regulation 180/69 (Edmonton: Queen's Printer, 1969) Sec. 4(1) and (2).

[8]British Columbia Medical Services Act (Victoria: Queen's Printer, Sec. 10. Also the Medical Grant Act establishes a medical grant stabilization fund of two million dollars a year to stabilize premiums of certified carriers. This is paid out of Consolidated Revenue, Medical Grant Act Amendment Act (Victoria: Queen's Printer 1966) Sec. 3(2). Both acts above provide that if premiums and the annual appropriation to the Medical Grant Stabilization Fund are insufficient further expenditures will come out of Consolidated Revenue Fund.

[9]Manitoba. The Manitoba Medical Services Insurance Act, op.cit., Sec. 15(1) and (2) and Sec. 45(1) and (2). General revenue refers to income from a variety of sources,e.g., natural resource revenue, sales tax that is recorded in the General Revenue Account. It does not include income that is collected and given directly to user, e.g., Hospital Insurance Commission.

[10]Newfoundland. The Newfoundland Medical Care Insurance Act, op. cit., Sec. 27(1), (2), (3), (4).

[11]Nova Scotia. Schedule of Agreement Between the Province of Nova Scotia and Maritime Medical Care Incorporated, op.cit., Sec. 3.

[12]Ontario. The Health Services Insurance Act 1967, op.cit.,Sec.34.

[13]Saskatchewan Annual Report 1968, Statement of Receipts and Payments for the Year Ended December 31, 1968, p. 32.

[14]Quebec. Budget Speech Quebec National Assembly, April 29, 1969, op. cit. 1969 single taxpayer of $2,000 or more will pay 1% of his net income. Married taxpayer with income over $4,000 will pay 1% of his net income. But in no event will it exceed $120. Employers to pay 8/10 of 1% of payroll.

[15]Dr. Clarkson, op. cit.

[16]E.N. Stefanuk. "Comparison of Provincial Hospital Plans," op. cit., pp. 46-47. Stefanuk used the term "consolidated revenue" rather than "general revenue" for all provinces except Alberta and Quebec. The two terms have the same meaning.

It is evident that the majority of provinces have decided to finance both of their major health plans by different methods. Ontario does not have joint collection of its health and hospital insurance premiums. One may question whether two methods of financing and two collection agencies are more efficient than one of each. During research for this thesis, no cost-benefit analysis for the various choices made by the provincial governments was encountered.

Premiums

Premium Amounts

The amounts of the premiums for the individual health insurance and hospital insurance plans are summarized in Table XIX. It can be seen from Table XIX that Ontario has the highest premiums under both plans. Furthermore, it is noted that when premiums are combined for health and hospital insurance, Ontario's premiums are more than twice that of other provinces.[18] It is obvious that premiums for health insurance programs in Saskatchewan and Manitoba are considerably lower than they are in the other provinces; however, it must be

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[17] K.C. Charron noted that in only Canada did he find Sales Tax and Property Tax used to finance health insurance. K.C. Charron. Health Services, Health Insurance and Their Inter-relationships, op. cit., p. 31.

[18] The Report of the Commission of Inquiry on Health and Social Welfare comments on premiums in this way

> "It should be remembered that the primary objective of health insurance, from the financing viewpoint, is cost-sharing necessary for the merger of risks among all the members of the community. Unless there is a ceiling on premiums the amount of premiums would involve an element of distribution of income, which is not within the scope of health insurance."

Report of the Commission of Inquiry on Health and Social Welfare, op. cit., p. 87. The Report further notes that if itis deemed advisable to further redistribute income, this should be done through other mechanisms, e.g., Income Tax Act--Negative Income.

remembered that in the other provinces, premiums pay for the total cost of plans.[19]

TABLE XIX

PREMIUM AMOUNTS FOR PROVINCIAL HEALTH CARE PLANS[20]
(PER ANNUM)

	Category	Health Care Insurance	Hospital Insurance	Combined Premiums
Alta.[21]	Single	$ 60.00	$ -	$ 60.00
	Couple	120.00	-	120.00
	Family	120.00	-	120.00
B.C.[22]	Single	60.00	-	60.00
	Couple	120.00	-	120.00
	Family	150.00	-	150.00
Man.[23]	Single	6.60	43.20	49.80
	Couple	13.20	86.40	99.60
	Family	13.20	86.40	99.60
Ont.[24]	Single	70.80	66.00	136.80
	Couple	141.60	132.00	273.60
	Family	177.00	132.00	309.00
Sask.[25]	Single	12.00	24.00	36.00
	Couple	24.00	48.00	72.00
	Family	24.00	48.00	72.00

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[19]It is interesting to note that Premium income in the Saskatchewan Medical Care Insurance Fund was only $5,776,563 for the year 1968, approximately 21.54 percent of total receipts. Annual Report 1968, op. cit., p. 32.

[20]The premiums given in the table are those for persons who because of limited incomes do not qualify for premium assistance. The provisions for assistance vary and will be discussed later.

[21]Alberta. The Health Insurance Premiums Regulations. Regulation 180/69, op. cit.

[22]British Columbia. "A Brief Description of Benefits Provided," op. cit., p. 4.

[23]Manitoba. "Information Regarding Hospital and Medical Insurance for Residents of Manitoba," op. cit., 4(c).

[24]Ontario. Health Services Insurance Plan. Ontario Department of Health, Information Bulletin.

[25]Saskatchewan. Saskatchewan Medical Care Insurance Commission, Annual Report, 1968, op. cit., p. 12.

Principles of Premium Method of Payment

Premium System and Social Responsibility

It is believed that in establishing a fixed legal relationship between benefits received and premiums paid, a sense of social responsibility is enhanced. Lord Beveridge argues in support of the contributory principle that,

> "...the citizens as insured persons should realize that they cannot get more than certain benefits for certain contributions, should have a motive to support measures for economic administration, should not be taught to regard the state as the dispenser of gifts for which no-one need pay."[26]

This argument has been reiterated both before and since the Beveridge Report. Eveline M. Burns notes that,

> "Far too little is known of the responsibility-inducing effect of the requirement of a contribution by the beneficiary. It is true that there is some evidence to suggest that at least when the unit of administration is small, so that excessive utilization of the program results directly and immediately in increased assessments against the members, all will be vigilant to keep costs to an acceptable minimum. This seems to have been the case with some of the early subsidized voluntary social insurance systems which were modeled upon the plans of trade union, friendly or mutual-benefit societies. But where schemes are national in scope and administration and where the contribution rate for many risks is combined in a single weekly or monthly deduction from wages, the restraining influence of the worker's contribution seems more doubtful."[27]

It should be remembered that one of the arguments in favor of a health insurance system was precisely that if a person paid a contribution he was entitled to benefits as a right. The belief

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[26] Sir William Beveridge. Social Insurance and Allied Services (London: H.M. Stationery Office, 1942), p. 108.

[27] Eveline M. Burns. Social Security and Public Policy (Toronto: McGraw-Hill Book Company Inc., 1956), p. 157.

that a person has paid for whatever benefits he receives may thus work in the opposite direction from that intended by those who view the contributory requirement as a brake upon unreasonable benefit increases or extensions.[28] The restraining influence of a person's contribution is even more questionable when some other groups, e.g., employers, general taxpayers, public assistance recipients, carry part of the costs.[29]

Problem of Equity

It is believed that the premium system allows for easier collection since the premium payer knows that if he has not paid his premiums he will lose benefit rights. As noted in Chapter III this is true in British Columbia and for the individual in Ontario.[30] Richard Musgrave considers this the benefit approach when the public-revenue-expenditure process is considered. He points out that the benefit approach, by its very nature, cannot solve the problem of the distribution of income and cannot maintain a high level of

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[28] Ibid., p. 157. Burns also noted that the average English worker who pays a social weekly security tax towards the costs of health insurance (accounting for less than ten percent of the costs thereof) appears to be under the impression that the service is wholly financed by contributions and that he is entitled to extensive benefits free of charge "because he has paid for them."

[29] Sir William Beveridge, op. cit., p. 166.

[30] The Report of the Commission of Inquiry on Health and Social Welfare notes that,

> "Eligibility for benefits in private insurance contracts is related directly to payment of premiums. Social insurance is based on different principles because its purpose is to protect the general public against certain risks of social nature. As opposed to private insurance, eligibility for benefits in health insurance should not be linked directly to the payment of premiums."

Report of the Commission of Inquiry on Health and Social Welfare, op. cit., p. 88.

resource utilization. However, in the matter of resource allocation this view has the merit of tying the choice of public services to the preferences of the individual members of the community. The approach also ties both sides of the budget process--revenue and expenditure. Musgrave notes that since this relationship is one of exchange-market mechanism,

> "We make the unrealistic assumption that the exclusion principle and, hence, the principle of voluntary exchange are applicable to the satisfaction of public wants. Moreover, such a solution overlooks the difficulty of determining the optimal output in the case of social wants, even if true preferences are revealed."[31]

The other basic approach is centered around the ability-to-pay criteria. In this approach the contribution to public services is treated as an independent problem. Taxes are seen as compulsory payments, and the revenue-expenditure process is viewed as a planning problem not subject to solution by the automatic functioning of the market. Under this method the allocation of resources, the distribution of income and the maintenance of a high level of resource utilization are included. Musgrave points out,

> "However, the ability-to-pay approach does not tell us just how the tax burden is to be distributed. Worse still, it disregards the expenditure side of the problem, or, at best, provides us with the dictum that expenditures should be planned so as to maximize welfare. The ability-to-pay approach collapses completely if one accepts the hypothesis of the newer welfare economics, that interpersonal utility comparisons are inadmissible."[32]

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[31] Richard A. Musgrave. The Theory of Public Finance, International Student Edition (Toronto: McGraw-Hill Book Company Inc., 1959), pp.62-63.

[32] Ibid., p. 63.

Premium Systems and Income Levels

The implementation of various methods of financing provincial health insurance plans involves the search for a compromise between a number of not wholly compatible objectives. One of the major objectives in many plans is a balance between health care revenues and expenditures; however, different types of taxes fall unevenly upon different sections of the population.[33] In effect, there is a trade off between the allocation of resources and the distribution of income. The data set out in Table XX is used to partially illustrate some of the distributive aspects of the premium method of financing health insurance plans.

Table XX indicates that with the exception of Quebec those provinces that do not use premiums are relatively speaking, low income provinces, e.g., Atlantic Provinces. It is interesting to note that Prince Edward Island, New Brunswick and Newfoundland at one time financed their hospital insurance program by use of a premium method, but have now reverted to use of provincial general revenues.[34] The provinces that have a higher percentage of their population receiving higher incomes have reverted to or implemented a premium system. Quebec is an exception again.

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[33]This discussion excludes persons who have their premiums paid under Public Assistance Programs.

[34]Royal Commission on Health Services, Vol. 1, op. cit., p. 414.

TABLE XX

PROVINCIAL AND REGIONAL CLASSIFICATION
OF INCOME AND PREMIUMS

	Premium System	Percentage of Population[35]	Income Class	Average Income	Median Income
B.C.	Yes	18.4	Under $999		
		15.6	1000-1999		
		14.5	2000-3499	$4381	$3646
		12.8	3500-4999		
		38.7	5000-Up		
Ontario	Yes	15.3	Under $999		
		13.9	1000-1999		
		14.3	2000-3499	$4711	$4124
		15.9	3500-4999		
		40.6	5000-Up		
Prairie Provinces	Yes	18.5	Under $999		
		17.7	1000-1999		
		17.0	2000-3499	$3938	$3219
		15.4	3500-4999		
		31.4	5000-Up		
Quebec	No	15.4	Under $999		
		16.1	1000-1999		
		18.1	2000-3499	$4111	$3522
		18.3	3500-4999		
		32.1	5000-Up		
Atlantic Provinces	No	21.1	Under $999		
		22.5	1000-1999		
		20.1	2000-3499	$3128	$2484
		15.9	3500-4999		
		20.4	5000-Up		
Canada		16.7	Under $999		
		16.1	1000-1999		
		16.3	2000-3499	$4240	$3579
		16.1	3500-4999		
		34.8	5000-Up		

[35] Dominion Bureau of Statistics. Income Distribution and Poverty in Canada (Ottawa: Queen's Printer, 1969).

Equity is achieved within a province when an examination is made of how premiums affect people with equal incomes. This is horizontal equity and the basic premise underlying this concept is that people with equal income incur equal burden of costs. Horizontal equity however, is not achieved on an interprovincial basis. As noted in Table XIX premium amounts vary widely from province to province. As a result, two individuals with the same income living in two different provinces would not incur an equal burden of costs. It should be noted that those provinces that use the premium system are also those provinces which provide in varying degrees health benefits over and above insured services. As a result, differentials in coverage of health services are not large in these provinces. Given the interprovincial differences in premiums it does not appear that horizontal equity is achieved on a nationwide basis even after allowances are made for the differences in health services provided by each plan.

Equity further breaks down when an examination is made of how premiums affect people with different income levels. This is vertical equity and the basic premise underlying this concept is that an equal burden should be placed on all individuals regardless of existing differentials in income levels. One of the major problems in examining vertical equity is that no basis or standard has been devised that will measure vertical equity. John F. Due has noted that this is because Modern Welfare Economics has accepted the premise that the principle of diminishing marginal utility cannot be argued scientifically nor can interpersonal utility

comparisons be measured. He further noted that vertical equity is a matter of value judgement based upon accepted attitudes towards an optimum distribution of income.

> "Since the justification for progression rests upon community consensus about standards of equity in the distribution of income, the devised degree of progression must rest upon the same basis. Thus, there are no objective criteria for the establishment of the scale of progression which must be determined on the basis of the interpretation of the exact degree of income inequality which is regarded as most acceptable by a consensus of thinking in society."[36]

Due notes that in terms of the primary measure, that is income, there are three possible scales of tax: progressive, proportional, and regressive. The premium system can be described as being regressive, because premiums are fixed as income rises--a lesser percentage share of disposable income is consumed in paying health insurance costs. Due states "that the consensus of opinion in society today regards progression as necessary for equity." The acceptance of this value judgement would mean that the premium system does not provide vertical equity. Musgrave states in this regard,

> "Without a scheme of vertical equity, the requirement of horizontal equity at best becomes a safeguard against capricious discrimination--a safeguard which might be provided equally well by a requirement that taxes be distributed at random. To mean more than this the principle of horizontal equity must be seen against the backdrop of an explicit view of vertical equity."[37]

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[36]John F. Due. Government Finance: An Economic Analysis (Homewood, Illinois: Richard D. Irwin, Inc., 1966), p. 117.

[37]Richard A. Musgrave. The Theory of Public Finance, op. cit., p. 160.

Because the premium system relies on the principle of individual equivalence between benefits and premiums, it is a benefit approach to the taxation of health insurance. The benefit approach rests on two assumptions: principle of voluntary exchange and the ability to tie and allocate health services to individual preference curves. Since health insurance provision has moved from a private to public sector these two assumptions no longer hold true. Health services marketed in the public sector are collective goods and it is difficult to separate individual goods received or purchased. The principle of voluntary exchange assumes further that both parties in the exchange process are knowledgeable and they bargain for their own benefit. However, when a person consumes health services he cannot determine the quality and quantity he needs. The problem rests on not differentiating between what a public good is and what a private good is. It would seem that those provinces that have chosen the premium system have decided to offer public goods and services according to the traditional principles on which private insurance is based.[38]

There also seems to be a considerable amount of confusion between the allocation and distributive functions of government. Musgrave in his book The Theory of Public Finance assumes that when one is talking about one of the functions of government (allocation) the other two functions (distribution and stabilization)

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[38]It should be noted, however, that goods and services provided by the private sector can take on characteristics of public goods if the private sector is regulated by government, e.g., Bell Telephone Co.

are being properly performed.[39] It is suggested that when one is considering the premium system this assumption cannot be made. Musgrave points out that the premium system (the Benefit Approach) by its nature cannot provide for the distribution of income. It was noted prior that the premium system does not provide vertical equity. If the value judgement can be accepted that some sort of progression provides equity, then the premium system does not provide a taxation system that is equitable based on ability-to-pay criteria.

Authorized Charges

There are two principle reasons for the imposition of authorized charges at the time of service.

(1) Control of costs of health and hospital insurance.

(2) Creation of a new source of income to finance health and hospital insurance.

There is little dispute that authorized charges at the time of service control costs. The Task Force Reports on the Cost of Health Services in Canada notes that personal patient-payment affects total costs. This is evident in Saskatchewan where the new patient fees have reduced routine office calls by 15%.[40] McNerney in an extensive study in the U.S. noted similar results.[41] The Saskatchewan Department of Public Health noted the reason for use of authorized charges.

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[39] Richard A. Musgrave, op. cit., p. 5.

[40] Task Force Reports on the Cost of Health Services in Canada, op. cit., p. 236.

[41] Walter S. McNerney. Hospital and Medical Economics (Chicago: Hospital Research and Educational Trust, 1962), p. 1423.

"Utilization Fees have been introduced for three basic reasons:

(1) It is desirable to eliminate the incidence of trivial and unnecessary demands on publicly supported health services.

(2) The Government wishes to reduce the public costs of medical care and hospital services.

(3) The Government believes that direct patient financial participation will encourage responsible use of services."[42]

One of the principle objections to the method is that,

"The apparent disadvantage is that they may not have the desired effect without penalizing the poor and deterring patients from making necessary visits . . . they deter people from seeking care at the beginning of an illness, but not in its later stages (not a medically sound principle).[43]

Another criticism of authorized charges is that although they may have a desirable effect on total short run costs, they do not provide desirable effects on costs, quality and quantity of health services in the long run. Specially authorized charges de-emphasize the importance of preventive health. The Task Force Reports stated in this regard:

"In addition, it would appear that little can be accomplished in checking the rapid rise in government expenditures generally by restraining or reducing expenditures on public health."[44]

Cost, quality and quantity are intertwined and interdependent. A control mechanism which considers as its objective the control of short run costs and ignores quality and quantity (both short and long run) is considering only one side of a very complex triangle.

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[42] Saskatchewan. "Utilization Fees," Information Bulletin, Department of Public Health, April 16, 1968.

[43] Task Force Reports on the Cost of Health Services in Canada, op. cit., pp. 235-236.

[44] Task Force Reports on the Cost of Health Services in Canada, No. 3, op. cit., p. 361.

The use of authorized charges as a method of financing health insurance is a debatable issue. The Report of the Commission of Inquiry on Health and Social Welfare noted:

> "On the one hand, it is difficult to imagine that were such a method otherwise deemed advisable, it could help reduce appreciably the cost of benefits for reasons given in the preceding paragraph. On the other hand, any saving effected in the cost of benefits would be partially wiped out due to increased administrative costs resulting from such a measure. . . . Also, the control effected through general deterrent charges was conceived at a time when the more flexible and effective techniques of statistical control by electronic computers were as yet unknown."[45]

In Saskatchewan, the Department of Public Health has noted "Utilization fees will not represent a new source of income for hospitals and physicians, as the fees they may collect will be subtracted from public payments received."[46] It should be pointed out that physicians in Saskatchewan are responsible for collecting authorized charges. The remittance they receive from the Health Insurance Plan is the agreed amount, less applicable utilization fees.[47]

The provinces that have decided to use authorized charges in their health care plans are noted in Table XXI.

With reference to Table XXI it should be noted that only the Province of Saskatchewan has used authorized charges at the time of service for its health insurance program whereas in hospital insurance, British Columbia, Alberta and Saskatchewan have used this method. Only in Saskatchewan is there a consistent treatment in both programs.

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[45] Quebec Report of the Commission of Inquiry on Health and Social Welfare, op. cit., p. 59.

[46] Saskatchewan, "Utilization Fees," op. cit.

[47] Saskatchewan Annual Report, 1968, op. cit., p. 15.

TABLE XXI

AUTHORIZED CHARGES AT THE TIME OF SERVICE

	Health Insurance	Hospital Insurance[49]
Alta.	None	Adults: $5.00 for first day and $2.50 per day thereafter. Newborn: $1.00 per day. Auxiliary Hospitals: $2.00/day
B.C.	None	$1.00 per day for standard ward care; $2.00 for each emergency or minor surgical outpatient treatment; $2.00 per day for day care surgical services.
Man.	None	None
Nfld.	None	None
N.S.	None	None
Ont.	None	None
Sask.[48]	$1.50 per office visit; $2.00 per home visit payable to physician.	Inpatient: $2.50 per day for 30 days and $1.50 thereafter to 90 days. Outpatient: $1.50 for physiotherapy only. Payable to hospital.
Que.	Details not yet known.	None
N.B.	Details not yet known.	None
P.E.I.	Details not yet known.	None

The authroized charges noted in Table XXI are basically of a fixed charge nature. They do not vary with the income of an individual. This is illustrated by the following example. A resident of Saskatchewan visits a physician's office three times during an illness and is hospitalized for 80 days. The percentage of his disposable income ($3500) is compared to that of a person making $7000 when both pay the same for authorized charges.

[48] Saskatchewan, "Utilization Fees," op. cit.

[49] E.N. Stefanuk. "Comparison of Provincial Health Insurance Plans," op. cit., p. 46. This refers to care provided at standard ward level.

Income $3500		
Authorized charges:	physician office	$ 4.50
Authorized charges:	hospital	135.00
		$139.50
Percentage of Disposable Income	.04	
Income $7000		
Authorized charges same as above		$139.50
Percentage of Disposable Income	.02	

In this context a similar analysis and comparison can be made with premiums. Authorized charges provide for horizontal equity, but do not provide for vertical equity.

It was noted that the Federal Medical Care Act states that the provinces may use any method of paying the providers of service as long as

> "...this does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons."[50]

The Act also deducts authorized charges at the time of service in the calculation of cost of insured services eligible for Federal Contribution.[51] The federal government has thus discouraged the provincial health insurance plans from using authorized charges. The effect of direct user costs on patient's ability to utilize health services seems to hinge on the term "reasonable." In Saskatchewan's case a $1.50 charge per office visit and $2.50 per home visit payable to physicians was thought to be "reasonable."

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[50] Canada. Medical Care Act, op. cit., Section 4(1)(b).

[51] Ibid., Section 5(4).

Public Assistance Recipients

The treatment public assistance recipients receive in both health and hospital insurance plans is summarized in Table XXII.

With reference to Table XXII it can be seen that the provinces that have used premiums as a method of financing make a distinction between those who are able to pay their own premiums and those who cannot pay their premiums or are required to pay only part of the cost of premiums. The provinces that have chosen not to use premiums as a method of financing do not make this distinction and as a result a person's financial status has no bearing on how he must bear the burden of premium cost or how it will be paid or partially paid by a government agency. The same observation can be made in hospital insurance except in the provinces of Alberta and British Columbia where authorized charges are paid by government if deemed uncollectable.

Opinions vary among social scientists as to which of the two methods is better. In some quarters segregation of indigent from non-indigent persons is felt by some to act as a control of costs and use of Social Security programs. Eveline Burns has noted in this regard,

> "In any case, public assistance continues to embody one condition which is generally regarded as being "deterrent" namely the requirement to undergo a test of need and to be dependent on the discretion of an administrator for decisions as to eligibility and amount of payment. This control relies for its effectiveness on the assumption that to most independent and self-reliant persons the procedures accompanying the application of a needs test will be regarded as humiliating that every effort will be made to avoid seeking this type of public aid."[52]

[52] Eveline Burns, Social Security and Public Policy, op. cit., p.65.

TABLE XXII

PREMIUMS, AUTHORIZED CHARGES AND PUBLIC ASSISTANCE RECIPIENTS

Province	Health Insurance	Hospital Insurance[53]
Alta.[54]	Premium amounts payable are graduated on a taxable income basis. A resident in receipt of social assistance benefits from the Dept. of Social Development has his premium paid in full. No authorized charges in this plan.	Allowance made for uncollectable amounts by Dept. of Health to hospitals for authorized charges. No premiums payable in this plan.
B.C.[55]	Premium amounts payable are graduated on a taxable income basis. The amount of premiums payable by a person who qualifies for social assistance is paid by the government (Municipal or Provincial) responsible for his medical care. No authorized charges in this plan.	Allowance made for uncollectable accounts where indigent is under social welfare. Provincial Government pays $1 per day in-patient or $2 minor surgery out-patient charge. Also $2 charge for day care surgical services and $1 for out-patient cancer therapy.
Man.[56]	Persons receiving public assistance including persons in receipt of mother's allowance, blind person's allowance, disabled person's allowance, old age assistance, social allowance, who are wards of the government, are eligible for benefits without payment of premium.	Insured services: Municipalities pay hospitalization premiums on behalf of indigent resident, ensuring coverage for insured services.
Nfld.	Since this is a non-premium plan and no authorized charges exist, a person's financial status would have no bearing on coverage. Residents are all qualified for coverage and no-one needs public assistance help for insured services.	Since this is a non-premium plan and no authorized charges exist a person's financial status would have no bearing on coverage. Residents are all qualified for coverage and no-one needs public assistance help for insured services.

[53] E.N. Stefanuk. "Comparison of Provincial Health Insurance Plans," op. cit., pp. 48-51.

[54] Alberta. "Alberta Health Care Plan," An Information Pamphlet (Edmonton: Queen's Printer, 1969).

[55] British Columbia. Regulations under the Medical Grant Act, op. cit., p. 5.

[56] Manitoba. "Information Regarding Hospital and Medical Insurance for Residents of Manitoba," op. cit., p. 4.

TABLE XXII -- Continued

	Health Insurance	Hospital Insurance
N.S.	Same as Newfoundland.	Same as Newfoundland.
Ont.[57]	Premium amounts payable are graduated on an income tax basis. Persons in receipt of social assistance are covered without application and without payment of premiums. Temporary assistance may be granted during unemployment, illness disability or financial hardship. No authorized charges in this plan.	Province pays premium for provincial welfare. Municipality pays hospital statutory per diem rate for indigent and Province makes unconditional grant to municipalities as compensation. Plan billed for difference between municipal and tentative approved per diem rate.
Sask.[58]	No premiums are payable by persons nominated by the Provincial Department of Welfare. Authorized charges will be paid by the Provincial Government for those who qualify under Saskatchewan Assistance Plan.	The Saskatchewan Assistance Plan provides assistance to residents who are in need. Persons who are nominated under the assistance program for hospital care coverage become beneficiaries of the Saskatchewan Hospital Services Plan, without payment of premiums.
Que.	Since this is a non-premium plan and no authorized charges exist, a person's financial status would have no bearing on coverage. Residents are all qualified for coverage and no-one needs public assistance help for insured services.	Since this is a non-premium plan and no authorized charges exist, a person's financial status would have no bearing on coverage. Residents are all qualified for coverage and no-one needs public assistance help for insured services.
N.B.	Same as above.	Same as above.
P.E.I.	Details of plan not yet announced.	Same as above.

[57] Ontario. "Ontario Health Services Insurance Plan 1969," Information Pamphlet.

[58] Saskatchewan Annual Report 1968, op. cit., pp. 13 and 17.

Many people, however, believe that the test of need is itself a deterrent to initiative.

> "It does not seem fair, in effect, to give certain cash allowances to beneficiaries of such legislation and to refuse them to persons whose income, generally a product of their work, is equal or hardly higher than the amount of the allowances. Moreover, this is tantamount to penalizing the socially assisted, in particular recipients of social assistance who agree to return to work for a salary hardly higher than the amount of allowances which they then no longer receive."[59]

> "We consider the assistance method to have serious disadvantages as a long run approach to the nation's social security problem. We believe that improvement of the American Social Security System should move in the direction of preventing dependency before it occurs and of providing more effective income protection free from the humiliation of a test of need."[60]

The Canadian Health Care System has chosen to use both methods (five provinces one method; five the other method).

With reference to Table XXII it should be observed that Alberta, British Columbia and Ontario (the provinces with the highest premiums) have tried to lessen the burden of premium cost for those in the lower taxable income[61] brackets. The objective is basically to introduce to a limited extent the ability-to-pay approach. A summary of premium subsidy levels in Alberta, British Columbia, and Ontario is made in Table XXIII.

Table XXIII indicates that each province has decided on different levels of income and different categories of people for

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[59] Quebec. Report of the Commission of Inquiry on Health and Social Welfare, op. cit., p. 73.

[60] United States. Social Security Act Amendments of 1950 (S.Rep. 1669, Calendar No. 1680, 81st Cong. 2nd Sess., 1950), p. 2.

[61] As defined by the Canadian Income Tax Act.

levels of subsidy.[62] It should be noted that none of the provincial scales gives consideration to families having more than three persons. Saskatchewan and Manitoba do not have any scale of subsidy based on taxable income.

TABLE XXIII

HEALTH INSURANCE PREMIUM SUBSIDY LEVELS

				Amount Payable Per Year Based On Taxable Income		
	Category	Full Premium	Zero	Less than $500.	Less than $1000.	Less than $1300.
Alta.[63]	Single	$ 60.00	$30.00	$30.00	$Full	$Full
	Couple	120.00	60.00	60.00	Premium	Premium
	Family	120.00	60.00	60.00		
B.C.[64]	Single	60.00	6.00	30.00	30.00	Full
	Couple	120.00	12.00	60.00	60.00	Premium
	Family	150.00	15.00	75.00	75.00	
Ont.[65]	Single	70.80	35.80	35.40	Full Premium	Full Premium
	Couple	141.60	70.80	70.80	70.80	Full Premium
	Family	177.00	70.80	70.80	70.80	70.80

The Report of the Commission of Inquiry on Health and Social Welfare has noted in this regard,

> "In effect, such a system is regressive and creates problems in the scaling of premiums payable by individuals and family units according to their income levels. In actual application, such a financing system would raise hard-to-solve problems regarding equity and would complicate administration of the plan. Obviously, it would be possible but at the cost of

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[62] It is interesting to note that the Economics Council of Canada defines the poverty level at $2,500.00.

[63] Alberta. "Alberta Health Care Plan," op. cit.

[64] British Columbia. Regulations Under the Medical Grant Act, op. cit., p. 5.

[65] Ontario. Information pamphlet, op. cit.

> administrative complications and the softening of the scale of premiums by graduating these according to the income of contributors."[66]

The report goes on to conclude that this flexibility in setting the amounts of premiums would mean the plan would closely resemble a joint financing system based on general revenues of the state and on contributions based on a percentage portion of personal income.

It would appear that there is confusion as to the primary purpose of health insurance in the public sector. Is its purpose to finance health insurance so that no distinction is made for different classes of individuals or is its purpose to provide assistance to those who cannot assume full responsibility for financial obligations? It would appear that the Canadian Health Care System is split on this issue (five provinces have chosen one method; five the other method). It is suggested that the provinces in their decision making process have made a value judgement as to the proper role of government. Those provinces which segregate indigent persons from the rest of the population have decided that the government's role is to help only those individuals who are in need. Those provinces that make no distinction between classes of people have decided to provide financial assistance to all their residents on an equal basis. While the importance of this social-political decision cannot be denied, it would appear that socio-economic

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[66] Quebec. Report of the Commission of Inquiry on Health and Social Welfare, op. cit., p. 86.

analyses were of minor importance in the decision making process. For example, in those provinces which segregate indigent persons, no cost benefit analysis was performed indicating the administrative costs of the various choices available to the provinces. If the Federal and Provincial Governments are concerned about rising health care costs, it would appear that an economic analysis of treatment of indigents may provide favourable returns.

Expenditures of Health Insurance

Payments Made to Physicians

The Task Force Reports on the Cost of Health Services in Canada noted,

> "In 1966, payment for the services of physicians in private practice in Canada amounted to $605 million out of a total operating cost of health services of $2.815 billion. The cost of physician's services had doubled since 1958. Recent estimates by the Federal Government indicate at least a $50% increase since 1966.
>
> The cost of providing professional medical care to a community depends on the method by which payment is made to the doctors . . . . A relatively unpredictable cost results from a use of a fee-for-service system which is not adjustable regardless of the volume of services rendered. In Canada the vast majority of medical services are paid for under such a system."[67]

Eveline Burns has noted that among the many problems health insurance must face one of the most crucial is that of

> "...devising methods of remunerating professional personnel which will attract and retain an adequate supply of practitioners and which will foster rather than impede, the rendering of services of high quality. The selection of appropriate methods of

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[67] Canada. Task Force Reports of the Cost of Health Services in Canada, op. cit., p. 229.

> remuneration has, in fact, been a major cause of controversy between governments and the professions."[68]

The differences between the Schedule of Benefits payable by an insurance plan and the Schedule of Fees recommended by official physician organizations in the various provinces are noted in Table XXIV.

With reference to Table XXIV it is indicated that only in the provinces of Ontario and British Columbia are the Schedule of Benefits and Schedule of Fees on a common year--1969. Alberta's Schedule of Benefits is the same as the 1968 Schedule of Fees. All other provinces are using a 1967 Schedule of Fees.[69]

Much discussion has taken place in an effort to have the Schedule of Benefits pay 100% of the current year's Schedule of Fees. The Task Force Report on the Cost of Health Services notes in this regard,

> "In Ontario the medical association insists that it will never do this; it regards the payments made by O.M.S.I.P. as a Schedule of Benefits not necessarily related to their own Schedule of Fees and says it will fight to retain each doctor's right to charge his own fees to the patient, regardless of the amount by O.M.S.I.P.
>
> Of the other provincial medical associations, only Newfoundland has fully adopted the viewpoint of British Columbia; Manitoba, Alberta and Nova Scotia appear to share Ontario's view."[70]

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[68] Eveline Burns. Social Security and Public Policy, op. cit., p. 139.

[69] With reference to Table XXIV it should be noted that British Columbia and Ontario have a higher standard of income per capita than the other provinces.

[70] Task Force Reports on the Cost of Health Services in Canada, op. cit., pp. 237, 238. British Columbia's position is indicated in Table XXIV.

TABLE XXIV

SCHEDULE OF BENEFITS AND SCHEDULE OF FEES

	Year of Schedule of Benefits	1969	1968	1967	1966	1965
Alta.[71]	1969	--	100%	--	--	--
B.C.[72]	1969	90%*	--	--	--	--
Man.[73]	1969	--	--	Approx. 85%**	--	--
Nfld.[74]	1969	--	--	90%	--	--
N.S.[75]	1969	--	--	100%	--	--
Ont.[76]	1969	90%	--	--	--	--
Sask.[77]	1969	--	--	85%***	--	--
Que.	Details not yet announced.					
N.B.	Details not yet announced.					
P.E.I.	Details not yet announced.					

*The British Columbia Plan has an agreement with the British Columbia Medical Association whereby the Schedule of Fees is altered by an agreed index.

**Manitoba's Schedule of Benefits has been slightly modified so that it does not quite agree in procedure and breakdown with the Schedule of Fees.

***Minus an authorized charge at the time of service

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[71]W.G. McPhail. Alberta Health Care Commission, Edmonton, Alberta.

[72]British Columbia. Agreement Between British Columbia Medical Plan and British Columbia Medical Association, June 8, 1965, Sec. 2(a).

[73]G.C. Patchett, Administrative Assistant Secretary to Commission, Saskatchewan Medical Care Insurance Commission, Regina, Saskatchewan.

[74]Newfoundland. The Newfoundland Medical Care Insurance (Physicians and Fees) Regulations, February 1969, Sec. 4(1).

[75]Nova Scotia. Medical Care Insurance Act, op. cit., Sec. 7(3).

[76]Ontario. "How Are My Bills Paid," Information Pamphlet, Ontario Health Services Insurance Plan, Toronto, 1969.

[77]Saskatchewan Annual Report 1968, op. cit., p. 15.

The right of the medical profession to establish its own set of fees has been seriously questioned by the Report of the Committee on the Healing Arts in Ontario.

> "We do note, however, that the members of professions that are licensed or similarly regulated, do have a monopolistic power conferred upon them by the prohibition of other members of the community from practising the arts and skills of each profession. The fee schedules have been established unilaterally by the voluntary associations of the professions. In these circumstances, there is always the possibility of conflict between the economic interests of the members of the profession and the general public interest. In our view, when the province confers certain powers on fee charging professions that indirectly enable them as a group to establish a general level of fees, it is appropriate that the Province should participate in the establishment of the fee schedule."[78]

What type of negotiation between the public representatives and the medical profession will take place can only be determined by future events.

Methods of Payment to Physicians on a Fee-For-Service Basis

One of the areas that has caused a considerable amount of discussion between physicians and individual health insurance plans has been the methods of payment.[79] The Task Force Reports note that,

> "From 1962 to 1968 and particularly in 1966 and 1967 the profession and the government in Saskatchewan entered into extended meetings in an attempt to rationalize the extrapolation of the payment rules which had been taken from the TCMP plans and incorporated in the government plan.
>
> In 1968 a whole new era was created when for the first time in Canadian history a government agency, namely the Saskatchewan

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[78] Ontario. Report of the Committee on the Healing Arts (Toronto: Queen's Printer, 1970).

[79] Quebec. Report of the Commission of Inquiry on Health and Social Welfare, op. cit., p. 143.

> government, unilaterally elected to record as a statute (regulations) the majority of the payment rules which had been in operation since inception of the plan in 1962.
>
> The facility with which this was accomplished creates a new set of ground rules as far as the profession is concerned in controlling in total, its own fee schedule. In reviewing this whole subject one must draw a line between how a fee schedule influences patterns of practice as opposed to how a fee schedule influences patterns of billing."[80]

The methods that have been provided in the individual health insurance plans by legislation and regulation are summarized in Table XXV.

Reference to Table XXV indicates that only in the provinces of Newfoundland and Saskatchewan must participating physicians accept payment from the Health Insurance Plan as payment in full.[81] In this respect these plans offer a "service" plan approach to health insurance. For non-participating physicians excess charges can be made in all provinces if agreement and arrangement is made before services are rendered. It should be noted that the procedures of prior agreement and arrangement before services are rendered are not the same in all provinces. For example, some provinces, e.g., British Columbia, require a written agreement whereas in Alberta a written agreement is not required. It would seem that a majority of the provinces have provided for excess billings by physicians over and above that payable by the individual provincial health insurance plans. As a result the majority of plans have been set up under the "indemnity" approach.

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[80] Task Force Reports on the Cost of Health Services in Canada, op. cit., pp. 257-258. TCMP refers to Trans Canada Medical Plans.

[81] The Task Force Reports on the Cost of Health Services in Canada notes "That the right of physicians to charge more than an insurance plan's Schedule of Benefits should be retained. However, if the doctor is prepared to accept direct payment from the plan, he should accept the plan's payment as payment in full except when he has informed the patient before rendering the service that there will be an additional amount for the patient to pay." The Task Force Reports on the Cost of Health Services in Canada, op. cit., p. 177.

TABLE XXV

METHODS OF PAYMENT OF HEALTH INSURANCE FOR PHYSICIANS

	Alta.[82]	B.C.[83]	Man.[84]	Nfld.[85]	N.S.[86]	Ont.[87]	Sask.[88]
Participating Physician							
I. A physician may send accounts and receive payment from Health Insurance Agency (Commission, Government Health Dept., or intermediary agency).	Yes	Yes	Yes	Yes	Yes	Yes	Yes
II. Physician must accept above as total payment.	No	No	No	Yes[85]	No	No	Yes
III. Physicians have the right to bill patient over and above the Schedule of Benefits if agreement and arrangement is made before services are rendered.	Yes	Yes	Yes	No[85]	Yes	Yes	No

[82] The Alberta Health Care Insurance Act, op. cit., Sec. 24(b). The Alberta Health Care Insurance Regulations, op. cit., Sec. 14.

[83] British Columbia Medical Services Act Regulations, op. cit., Division 5.

[84] Manitoba. The Manitoba Medical Services Insurance Act, op. cit., Sec. 39, 40 and 41.

[85] Newfoundland. The Newfoundland Medical Care Insurance Act, 1968, op. cit., Sec. 22, 23 and 24. Where a participating physician who is a specialist provides insured services to a beneficiary who has not been referred to him by another physician, he may make charges against that beneficiary in excess of the amount payable to him by the Commission provided he informs the beneficiary before furnishing the insured services. The Newfoundland Medical Care Insurance Act, 1968, op. cit., Sec. 22(3).

[86] Nova Scotia. Medical Care Insurance Act, op. cit., Sec. 19, 20 and 21.

[87] Ontario. "How Are My Bills Paid," Ontario Health Services Insurance Plan. An Information Pamphlet.

[88] Saskatchewan. Annual Report 1969, op. cit., p. 14.

TABLE XXV -- Continued

	Alta.	B.C.	Man.	Nfld.	N.S.	Ont.	Sask.
Non-Participating Physicians							
I. A beneficiary may send accounts and receive payment from Health Insurance Agency (Commission, Government Health Dept., or intermediary agency).	Yes	Yes	Yes	Yes	Yes	Yes	Yes
II. Physician must accept above as total payment.	No	No	No	No	No	No	No
III. Physician has the right to bill patient over and above the Schedule of Benefits if agreement and arrangement is made before services are rendered.	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Details of methods of payment for the Provinces of Quebec, New Brunswick and Prince Edward Island have not been disclosed.

All plans have provided in the legislation that a physician is not compelled to practice within a health insurance plan. The Report of the Commission of Inquiry on Health and Social Welfare has noted,

> "On the other hand, the Commission also believes that the health insurance act should provide that the fees negotiated in any agreement automatically should apply to all members of the relevant profession, providing, however, for the possiblity of "individual opting out." In effect,it seems necessary, in order to respect the character of the professions, to allow professionals in the health field to opt out of the plan as individuals. Health insurance legislation, however, should prohibit this individual right of opting out when, in any given region or in any given category of practitioners in any given region, this personal opting out takes the shape of group opting out which only could be construed as the result of collusion among the principal parties concerned; in such a case, therefore, in the opinion of the Commission, the spirit of this right of opting out would be denied."[89]

There is a definite relationship between opting out procedures, differences in the Schedule of Benefits and Schedule of Fees, and the type of payment for physician services. It would appear that the Canadian Health Care System has selected to use different combinations of the above. The different choices made by governments and physicians have different effects on the Canadian populace. No studies were encountered that examined the cost and benefits of the various alternatives made by a health insurance plan before the plans went into operation. Research should be conducted that will examine the consequences of the various alternatives.

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[89] Report of the Commission of Inquiry on Health and Social Welfare, op. cit., p. 141.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

The individual provincial government's response to the Federal Medical Care Act has resulted in the formulation of health insurance structures that have a number of similarities and dissimilarities.

Dates of Implementation

From the beginning the implementation dates of the individual health insurance plans have varied greatly. At the present time, Quebec, Prince Edward Island and New Brunswick do not have any health insurance plans in operation. In these provinces approximately 37% of the population do not have coverage for health insurance benefits.

Administration

The administration of health insurance plans seems to have conformed to two patterns. Seven provinces have chosen a commission basis; two provinces a departmental basis. When a comparison is made between health insurance, hospital insurance and public health, only the Province of New Brunswick has a consistent form of organization in all three areas. Only two (Alberta and British Columbia) of the seven provinces that have chosen a commission basis for health insurance do not designate that a certain number of members on the commission must be physicians representing medical associations

or societies. Only the Province of Quebec meets the recommendation of the Royal Commission on Health Services that representatives of the public health professions and government be included as members of the commission. Quebec and Saskatchewan are the only provinces which restrict the number of physicians that may be on the commission. Five provinces have chosen to use intermediary agencies to collect premiums and make payment of benefits. The Province of Ontario has the largest number of these intermediary agencies--40.

Requirements for Eligibility

The basic patterns and principles which were established as qualifying conditions for eligibility for health benefits are varied. In four of the provinces residence is the only requirement for eligibility of benefits. In the other four provinces in which details are available residents are required to register to be eligible. Of the latter group only in the Provinces of Alberta and Saskatchewan are fines set out in legislation if registration is not completed. Only two (Manitoba and Alberta) of the five provinces that have used premiums as a method of financing do not make payment a mandatory requirement before an individual is eligible for benefits. Only in the Provinces of British Columbia and Ontario (for those not in mandatory or collector's group) is there no legislation for a fine if premiums are not paid. In these provinces, health insurance in the private sector may not sell insured services and as a result a person's only alternative to government approved health insurance is not to have any health insurance at all.

Portability

The provisions for portability are quite similar in all provinces. The waiting period for an individual coming from a participating province is generally three months before he is eligible for benefits. There are exceptions; in the Province of Alberta residence is the only requirement and in Ontario there is a one month waiting period for those individuals entering a mandatory or collector's group. A consistent policy has also been maintained in hospital insurance. Alberta again provides the only exception to the three month waiting period. Ontario may also be said to provide an exception but only for those on a mandatory or collector's group. All provinces except Ontario and Alberta provide at least three month's extension of coverage on loss of residence. In Ontario and Alberta loss of coverage takes place whenever a person becomes eligible for coverage in a new province of residence. This has resulted in an exception to the general three month lag in eligibility for benefits in a new province of residence. If a person moves from Alberta to Ontario and enters a mandatory or collector's group a waiting period of one month results.

Six of the provinces providing out of province benefits for residents temporarily absent from the province pay benefits on amounts as would be assessed if resident required treatment inside the province.

Extent of Benefit Coverage

All of the programs reviewed had a basic element of health

services covered--all services that are deemed to be "medically required" as defined in the Federal Medical Care Act. There are, however, a large group of health services which are not included as "insured services." If a province includes these as health benefits under their provincial health insurance plans financial assistance for these services is not available from the Federal Government. Some of the important health services in this category are:

(1) Prescribed drugs sold only at retail outlets.

(2) Services of a private duty nurse, chiropractor, osteopath, and optometrist.

(3) Dental services.

(4) Prosthetic services.

(5) Naturopathy.

Although these services are not eligible for a contribution under the Federal Medical Care Act, a number of provinces have chosen to provide these services to a limited extent--limited as to volume per year and/or limited to a specific dollar amount per visit or per annum. British Columbia has the widest and most extensive coverage of these services. There is not, however, an overall consistency as to coverage of these benefits. The only consistency that can be shown is that Nova Scotia and Newfoundland do not have any coverage for these benefits.

Methods of Financing

Different methods are used by the various provinces to finance health insurance. Five provinces have selected to use a premium

method of financing. Saskatchewan and Manitoba finance their health insurance programs by a combination of premiums and general revenue. The Atlantic Provinces use general revenue as the sole method of financing their programs. No provinces have used sales tax. Only the Province of Quebec has used a tax based on percentage of income collectable through Quebec's own personal income tax mechanism. Quebec also uses a tax on corporations based on 8/10 of 1% of payroll collectable through Quebec's own corporations tax mechanism. Four of the provinces participating in the Federal Medical Care Act have used the same method to finance hospital insurance as they used for health insurance. Alberta, British Columbia and Quebec have used completely different methods of financing their health and hospital insurance plans. Saskatchewan is the only province, of those that have used premiums to finance both their health and hospital insurance, that has joint collection of premiums through the same collection agency.

The provinces that have used premiums to finance their health insurance plans have used a wide variation in the amount of premium that is payable. The Province of Manitoba has the lowest premium, i.e., family $13.20 per annum. The Province of Ontario has the highest premium, i.e., family $177.00 per annum. When hospital and health insurance premiums are combined, Saskatchewan has the lowest, i.e., family $72.00 per annum and Ontario again has the highest at $309.00 per annum. The belief that a premium payment has the effect of restraining a person from using health services is a debatable point. One of the major problems has been to treat and think of

premiums in particular, and health insurance in general, as if they were still in the private sector of the economy. In the private sector no deviation can be made in the principle of individual equivalence between premiums and benefits. One of the objectives of health insurance in the public sector is the merger of social risks (a distribution of income and health resources). The principle of individual equivalence does not provide this. Therefore, a clear distinction must be made between health insurance in the public sector and health insurance in the private sector.

Income Levels and Premiums

The provinces except Quebec that have a lower per capita income do not use premiums as a method of financing health insurance; the provinces with a high per capita income have used premiums. Premiums are a regressive taxation method of financing health insurance.

Income Levels and Authorized Charges

Authorized charges exist in health insurance only in the Province of Saskatchewan. Only the Provinces of British Columbia, Alberta and Saskatchewan have authorized charges in their hospital insurance programs. Authorized charges are regressive in nature. The belief that they are an equitable method to control health expenditures is a debatable point.

Public Assistance Recipients, Premiums and Authorized Charges

The Canadian health insurance system has chosen basically

two methods of treating public assistance recipients. One method makes a distinction between those who can and those who cannot pay their premium. For those who cannot pay, a means test (usually taxable income) is used to determine the extent of partial payment required, if any. The tests for determining need in the Provinces of Alberta, British Columbia and Ontario are different because each province has decided on different levels of income and different categories of people for levels of subsidy. Consideration is not given to families having more than three persons. Saskatchewan and Manitoba have no scale of subsidy based on taxable income. All of the five above provinces pay premiums in total, or they exempt welfare recipients from payment (includes authorized charges in Saskatchewan). A similar situation exists in hospital insurance except in the Provinces of Alberta and British Columbia where authorized charges are paid by government if deemed uncollectable. Since the remaining provinces (Quebec and Atlantic Provinces) do not have premiums or authorized charges, a person's financial status does not have a bearing on how he must bear the burden of premium cost or how it will be paid or partially paid by a government agency. Which of the methods is better is basically a value judgement, i.e., one's philosophy as to the proper role of government.

Schedule of Benefits and Schedule of Fees

Only in the Provinces of Ontario and British Columbia are the Schedule of Benefits and Schedule of Fees on a common year--1969. The Schedule of Benefits pays only 90% of Schedule of Fees. Alberta uses a 1968 Schedule of Fees whereas all the other provinces use

the 1967 Schedule of Fees.

Fee for Service and Extra Billing

In most of the provinces the right of a physician to charge over and above the Schedule of Benefits has been retained by both participating and non-participating physicians. The exceptions to this are the Provinces of Newfoundland and Saskatchewan where participating physicians must accept as payment in full reimbursement from health insurance for services rendered. In all of the provincial health insurance plans provisions are made in statute for a physician to be either a participating or non-participating physician at the physician's will.

OBSERVATIONS

The primary purpose of this thesis was to survey the techniques and principles used in the individual provincial health insurance plans and in some instances to compare the advantages and disadvantages associated with their arrangements for health insurance. Rather than offer solutions to the many complex problems associated with this field, it seems preferable to focus attention on some features which may need careful study and appraisal in developing an effective and efficient health care delivery system. There is however, the danger of making generalizations as to the social and economic effects of health insurance programs. Their precise nature can be ascertained only by detailed analysis of the specific provisions regarding benefits, eligibility conditions, methods of financing, and nature of administration of each individual

plan. A knowledge of the basic techniques and principles can assist with the approval of our own health services, and can also help with the developments which might take place in the future.

Health Legislation

Canada is a young nation; however, some of its legislation relating to health services at the federal and provincial levels is already considered to be obsolete. A current review of the constitution is now being made by both the federal and provincial governments. Many of the health insurance programs now in existence contain provisions which were considered necessary and justifiable at the time when the programs were first introduced and when it was essential to embody certain safeguards to reassure those who feared the consequences of a new experiment. Many features of contemporary plans mirror the degree of administrative inexperience that necessarily prevail when a new social security plan is first adopted. Eveline Burns notes in this regard,

> "Again and again it has been shown that societies include provisions in their laws because of a belief that individuals are motivated to economic activity by certain devices or stimuli or because they believe that these legal provisions will have certain economic or social results. Yet many of their assumptions are untested, and until they are verified there can be no assurance that the social security institutions are well adapted to the needs and circumstances of the nation."[1]

In a review of health legislation at the provincial and federal level it would seem desirable that one of the objectives

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[1]Eveline Burns. Social Security and Public Policy, op. cit., p. 279.

to keep in mind would be the creation of an integrated health legislation system. It would appear that health insurance legislation at the provincial and federal levels has been developed in a vacuum. Little effort has been made to relate health insurance to other health legislation. In many respects health insurance legislation has confirmed the isolation of such patients as the mentally ill and tuberculosis victims. If coordination and integration of the Canadian health care delivery system is a desirable objective, then this objective will not be accomplished until leadership is shown by the federal and provincial governments in drawing up health legislation to make this objective possible. In this regard consideration should also be given to the advantages which might be derived from a greater degree of consolidation of health legislation. Present legislation presents a bewildering picture and consolidation seems to have definite advantages. For example, the Department of Health and Social Security in the United Kingdom notes,

> "It is the need to remedy these deficiencies and to meet those needs which are not at present fully met that dictates the kind of unified service required. The existing division of the service into three parts must be abolished in fact as well as in name. All decisions on staffing, planning and the deployment of resources must be governed by the total health needs of each area. One authority must be responsible for the National Health Service in each area and it must administer the services of each district as a whole. Only if there is a total merger of hospital and community health services in the administration of health district and area services will resources be efficiently deployed to meet the needs of each patient."[2]

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[2] National Health Service, The Future Structure of the National Health Service (London: Her Majesty's Stationery Office, 1970), p. 5.

It would appear that in organizing and financing their health care systems, the Provincial health authorities might benefit from the experiences of the British Health Care System.

When federal health legislation affects the provinces, it is usually couched in general terms. This allows the provinces flexibility in meeting the needs of their localities and provides room for change consistent with progress in health care. There is, however, also a need for basic uniformity in provincial health legislation particularly when matters of reciprocity are involved. For example, in portability provisions, there does not seem to be any strong argument why eligibility for benefits in a province cannot be standard for the Dominion. Current health legislation does not provide fully for this. It would seem that the role of the federal government as a standard setter of all Canadians has slackened somewhat by providing too much flexibility in some areas.

Administration

One of the important basic concepts in health services is to ensure continuity of health care. The administrative pattern for health services should facilitate the achievement of this objective. The trend toward isolation of administration into separate compartments (Public Health, Hospital Insurance and Health Insurance) both legally and administratively could hamper coordination of health services and continuity of patient care. A number of publications have noted the misallocation of our health expenditure priorities in terms of diagnostic and curative aspects of health

whereas public health and preventive programs have not been developed to their potential.[3] The Task Force Reports on the Cost of Health Services state that

> "It is our belief that an increase in the non-treatment (i.e., Public Health component) may make a substantial contribution towards the objectives set out for all task forces of maintaining the costs of health services at a reasonable level."[4]

Keeping this in mind it would seem that in any proposed development in the future, the importance of public health and prevention should be given an increasingly important role in health care. One wonders how effectively and efficiently a coordinated effort will ensue if public health is organized legally and administratively separate from hospital and health insurance.

It is not known to what extent integration and coordination of health and hospital insurance will take place under the present system. During research for this thesis no Canadian studies were encountered that examined the cost-benefits of separate and combined programs. However, the operation of interdependent health programs (hospital and health insurance) through separate administrative bodies (Commissions and Departmental) represents a costly duplication of functions. Both hospital and health insurance programs have personnel performing tasks regulating the flow of individuals immigrating and emigrating to and from their respective provinces.

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[3] Task Force Reports on the Cost of Health Services in Canada, No. 3, op. cit., p. 361.

[4] Ibid., p. 361.

If the provincial governments are interested in increasing efficiency in their health care systems surely these tasks could be performed by combining the functions and streamlining and standardizing the system.[5] Standardizing and streamlining the system would free public health administrators from some routine tasks and thus enable them to devote more time to areas that have a higher benefit-cost ratio, e.g., high level policy decision making.

The government's efficiency and effectiveness in organizing its component of the health care delivery system has direct effects on the effective organization of health services in other areas. There is a need to bridge the gap between hospital medicine and private practice medicine. Physicians need full access to pathological, ratiological and other diagnostic facilities which have been provided in hospitals. Physicians, however, are not held responsible for costs incurred in these areas. The physician's responsibility for these costs will not ensue until there is a closer link between medicine practised in and out of the hospital. Organizing and financing health and hospital insurance under different organization does not promote this link.

As was noted prior (Chapter III) the provinces have not chosen to legislate representation on commissions in accordance with the recommendation of the Royal Commission on Health Services. The Royal Commission Inquiry into Civil Rights in the Province of

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[5]This of course does not assume that one of the objectives of government is to employ people.

Ontario has noted in regard to the powers of self-regulating professions,

> "The public interest may have been well served by the respective bodies which have brought to their task an awareness of this responsibility to the public they serve, but there is a real risk that the powers may be exercised in the interests of the professions or occupations rather than in that of the public. The risk required adequate safeguards to ensure that injury to the public interest does not arise."[6]

The Commission recommended that "lay" representation be appointed by the Lieutenant-Governor to the governing bodies of all self-governing professions. There does not seem to be any reason why the rationale for this recommendation does not also hold true for commissions created to govern health insurance. It is also important that other health personnel (e.g., besides physicians) affected by health insurance policies be represented on commissions. If the federal and provincial governments decide that chiropractors, optometrists, etc., provide a medically useful service there does not seem any reason why their voice should not be represented. If the provincial governments believe in formulating policies only after they have heard the voice of the people, then it is necessary to examine the representation of the public on boards and commissions.

Health Benefits

The Royal Commission on Health Services has noted,

> "We have emphasized that if all Canadians are to have available adequate health services, the planning of health services and

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[6]Ontario. Royal Commission Inquiry into Civil Rights, Report Number 1, Volume 3 (Toronto: Queen's Printer), p. 1166.

> the health care coverage available must take account of adequate standards of health services for Canadians from one end of the country to the other, as well as the necessity to provide an appropriate level of health personnel and facilities to implement the health care program."[7]

The Federal and Provincial health insurance statutes do not provide for standards of quality care nor do they guarantee accessibility to health personnel and facilities. The health insurance system in Canada only provides financial assistance for health services if qualified care is obtained. If standards of care and guaranteed accessibility are included in a definition of health as a right, then the Canadian populace is not receiving health services as a right.

The Canadian health insurance system is facing a major decision. It must decide if it is going to develop one national health insurance system or ten distinct and not necessarily similar health insurance systems. At present coverage of benefits varies greatly over the Dominion. Three provinces do not have health insurance provided in the public sector. These are the provinces in which a high percentage of the population does not have health insurance coverage provided by the private sector. Two provinces (Nova Scotia and Newfoundland) provide only the minimum coverage needed to become participating provinces. The remaining five provinces provide benefits over and above the minimum required. Yet even here there is a wide variation in coverage with British

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[7] Royal Commission on Health Services, op. cit., p. 81.

Columbia providing the most extensive coverage. The Canadian populace does not enjoy equal access to financial assistance on the incurrence of health services.

Financing of Health Plans

The proportion of expenditures at the three levels of government shows clearly that the federal government carries the major burden of health care costs. There is, however, an increase in percentage of total public health expenditures being borne by the provinces. Herein lies one of the major administrative problems in health services in Canada. The institutional jurisdiction for these services is now plainly admitted to be with the provinces. The municipalities, confined to the use of the property tax, find their revenues inelastic. The provinces are burdened with maintaining expenses for education, urban renewal, roads, etc., as well as health. This has caused a strain between the federal and provincial governments regarding intergovernmental expenditure patterns.

The sources of finance of the various provincial programs also contribute to administrative complexity. The costs of public health and the wholly provincial health services (i.e., mental health services) are met solely from provincial general revenues. Hospital insurance and health insurance financing is met by a variety of methods.

All of these interrelationships in the financing of the health services have marked effects on the design and operation of

the services, and on the nature, extent, accessibility and effectiveness of each particular service. This complex and cumbersome method of financing has resulted in the development of formal machinery of inter-governmental cooperation, most of it primarily concerned with legal auditing and treasury control. The present system has stressed legal and financial accountability and has done little as to social accountability. As a result, concern for the quality, accessibility, and uniformity of health services has not been given equal priority. Yet these are the consequential determinants that will build an effective and efficient health care delivery system for the Canadian populace.

Premiums

Five provinces have chosen to use premiums as a method of financing health insurance programs. Three of these provinces (Alberta, British Columbia and Ontario) subsidize payment for individuals who are unable to pay the full premium amount due. Ability to pay is determined by a means test based on differentials of taxable income. The provinces that have used the premium system are also those that separate indigent individuals from the rest of the populace and either waive or pay premium amounts for them. An economic analysis of this system should be made. It would appear that this system is more costly to administer than a non-premium system.

Method of Payment of Physicians

The method of paying physicians is one area where much

discussion between the government and the medical profession is and will continue to take place. The success of a health insurance system will depend on the success of these discussions. In view of the social and economic implications of these negotiations it would appear that they should take place within a legal framework. The task of drawing up this legislation will not be an easy one because it transposes labour relation techniques from the industrial field to the field of the professions. Modifications will have to be made. Lack of such a framework places the negotiations of each party before heavy pressure due to the uncertainty in the event of a deadlock.

The differences between the Schedule of Benefits and the Schedule of Fees and the effect they have on a physician charging over and above his reimbursement from the health insurance agency must be examined. The majority of provinces allow a participating physician to excess charge. If some provinces cannot keep the gulf between the Schedule of Benefits and the Schedule of Fees at a respectable margin a new financial barrier to health services may be created for the Canadian populace.

Main Conclusion

This thesis has indicated that there is a lack of comparability and consistency in the administrative and economic structure of health care plans in Canada. A number of comments have been made which seem to indicate that it is possible to minimize a portion of the administrative costs which are presently being incurred by a number of the plans.

The question remains why this system has been created. It is suggested that there are two main reasons for this state of affairs:

1) the various govenments have not carried out the requisite social-economic research required to minimize the costs of supplying a large volume of high quality health services. In effect the governments may not be aware of other least-cost alternatives; and/or

2) ideological differences among the various governments have excluded certain feasible alternatives for minimizing health care delivery costs from the consideration of the respective governments.

The main conclusion of this thesis is that the various levels of government in Canada should undertake a careful reappraisal of the existing methods of providing health services across the Dominion. The following specific considerations should be kept in mind.

1) Integration of public health, health insurance and hospital insurance under one administrative body.

2) The elimination of intermediary agencies.

3) The adoption of the recommendations of the Royal Commission on Health Services as to representation on Commissions.

4) The adoption of uniform procedures across the Dominion as to eligibility of benefits, waiting periods, etc. Consideration should be made here with respect to eliminating the waiting periods.

5) The provincial governments should conduct research to determine to what extent they are financing medically useful health

services, i.e., chiropractors, etc.

This reappraisal should be done with the understanding that the objectives of the exercise are to maximize the net benefits obtained from public expenditures in health care. Minimization of health care administration costs are an obvious step in this direction. It is suggested that the federal government must assume the major responsibility for the existing situation in the sense that it is the only government which can establish national standards and enforce these standards by eliminating its financial support for provinces which are unwilling to attempt to minimize these costs.

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